



Carroll County Memorial Hospital

A Partner of  Health

FINANCIAL ASSISTANCE APPLICATION

Thank you for choosing Carroll County Memorial Hospital (CCMH) for your healthcare needs.

We are pleased to provide you with this Financial Assistance Application to determine if you meet the eligibility criteria for assistance with your hospital bill from CCMH. For your application to be processed, we require the following:

- Completed, signed and dated financial assistance form (attached)
- Copy of your most recent state and federal tax return
 - If self-employed, the last two years of tax information
- Copies of the **two most recent pay stubs** for all wage-earners who live in the household
- Copies of the **two most recent bank statements** including checking and savings
 - If you do not have a bank account, provide two months of receipts or check cashing services (for rent, utilities, etc.) or utility bills paid in cash
- Proof of other income to include unemployment benefits, workman's compensation benefits, social security/retirement benefits, government assistance (food stamps, WIC, etc.), child support, disability benefits, etc.
- Proof of other income source documented in the application
- Information about your family's gross monthly income (before taxes/deductions)
- Declaration of assets
- **Two most recent investment statements** if applicable. To include: HSA, FSA, stocks, bonds, CDs, 401K

Please mail or drop off the completed application to:

Central Registration
309 11th Street
Carrollton, KY 41008

We will notify you of the final determination of eligibility within 30 calendar days of receiving a complete financial assistance application, including all required supporting documentation noted above.



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Patient Information			
Name:			
Date of Birth:	SSN:	Phone:	
Current Address:			
City:	State:	Zip Code:	
Rent ☐ Own ☐			
Name of Person Responsible for Paying Bill (Guarantor):			
Relationship to Patient:			
Date of Birth:	SSN:	Phone:	
Marital Status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐			
Employment Status of Person Paying Bill:			
Employed date of hire:		Unemployed (how long):	
Student ☐ Disabled ☐ Retired ☐ Other ☐			
List the following information for the family members (including patient/self) living in the household:			
Name	DOB	Relationship to Patient	
Monthly Income			
Patient or parent's gross income (mom's monthly)		\$	
Patient or parent's gross income (dad's monthly)		\$	
If you have no income, who pays for household expenses?			
Other gross income	Source:	\$	
<i>Includes child support/alimony, social security, SSI, unemployment, food stamps, pension, etc.</i>			
Monthly Expenses			
Rent/Mortgage	\$	Food/Supplies	\$
Telephone	\$	Utilities	\$
Medical	\$	Auto	\$
Insurance	\$	Other	\$
Assets			
Checking balance	\$	Savings balance	\$
Other	\$		



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Assets cont.

Check all that apply to any household member:

401K ☐ Stocks ☐ Bonds ☐ HSA ☐ Trusts ☐ Property ☐ Owns a business ☐

Other (please list):

Have you applied for Medicaid or any other state/county assistance? Yes ☐ No ☐

If yes, please provide the following:

Application date: Status of Application: Caseworkers Name & Phone #:

**CCMH Financial Counselor will screen patient for Medicaid (3rd party) and attach supporting documentation to the application.

Please attach additional pages if there is more you wish for us to know regarding your current situation.

By signing below:

- I certify that the information I have provided is true and accurate to the best of my knowledge.
- I will independently or with the assistance of CCMH personnel apply for ANY and ALL assistance which may be available through federal, state, local government and private sources to help pay for this hospital bill.
- I understand that if I do not cooperate with CCMH in providing the information requested that my application may be denied for possible financial assistance.
- I understand that the information I have submitted is subject to verification by CCMH, including credit reporting agencies and is subject to review by federal and/or state agencies and others as required.
- I understand that additional information may be requested in order to qualify for assistance.

Patient Name (print): _____ Date: _____

Signature of Applicant: _____ Date: _____