Carroll County Memorial Hospital

Your Community Your Hospital

Charity Application

Dear Valued Patient:

Carroll County Memorial Hospital is glad you chose our hospital and is proud to provide healthcare services to you. You have registered and received services without providing proof of insurance. Due to this, costs associated with your visit are your responsibility.

You can apply for state Medicaid assistance through the hospital. If you do not qualify for Medicaid assistance, you can also apply for hospital charity. In order to receive any assistance you must comply with all requests both at the time of service and also after the date of service. This will require you to be present for review at your county's social services office at a future date. If you do not attend, financial assistance will not be granted. Cooperation does not guarantee assistance as this is based on meeting state guidelines. In addition, lack of cooperation will eliminate any consideration of charity assistance through our hospital.

By signing below, you are stating that you understand what is expected in receiving these services without paying and will meet expectations stated above. If you do not cooperate both now and in the future the hospital will use all means necessary to collect the debt you have incurred.

_____ _____

Signature **Date**

309 Eleventh Street Carrollton, Kentucky 41008 502-732-4321

Carroll County Memorial Hospital
Application for Financial Assistance (Charity Care)

Patient Name: _____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Patient SSN: _____

Guarantor Name: _____

Address (if different from Patient): _____

_____

Home Phone: _____ **Cell Phone:** _____

Guarantor SSN: _____

Guarantor Employer: _____

Address: _____

_____

Work Phone: _____

Number of Household Members Living at Home: _____

Please list Name, Age & Relationship of Each Household Member:

_____

_____

_____

_____

Monthly Income Verification

- Patient's Income (or parent's, if patient is a minor): _____
- Spouse's Income: _____
- KTap: _____
- Child Support/Alimony: _____
- Social Security: _____
- SSI/Disability: _____
- Unemployment: _____
- Pension: _____
- Food Stamps: _____
- Other Income? IF yes please list: _____

Total Monthly Income: _____

Monthly Expenses Verification

- Rent/Mortgage: _____
- Food/Supplies: _____
- Clothing: _____
- Utilities: _____
- Telephone: _____
- Childcare: _____
- Hospital Insurance Premiums: _____
- Prescription Expenses: _____
- Other Expenses? IF yes please list: _____

Total Monthly Expenses: _____

Resources:

- Checking/Savings Accounts – Current Balance: _____
- Stocks/Bonds – Current Value: _____
- Other Resources? IF yes please list: _____

Total Resources: _____

Property:

Home Mortgage Name: _____

Address: _____

_____

Current Value/Equity: _____

Auto #1 Information:

Year/Make/Model: _____

Owner: _____

Current Value/Equity: _____

Auto #2 Information:

Year/Make/Model: _____

Owner: _____

Current Value/Equity: _____

Other Property/Autos? IF so, please list:

_____

_____

_____

_____

Medical Expenses – Please list by facility/physician name & balance:

_____

_____

_____

_____

This certifies that I request to be considered for financial assistance at Carroll County Memorial Hospital (CCMH). I agree to furnish CCMH with any information necessary to determine my eligibility for assistance with medical bills resulting from the services I have received at CCMH. I understand that failure to complete and return this requested information within 30 days may result in the denial of my request for assistance.

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold any information in applying for this assistance, my application will be denied and CCMH will continue to pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I also agree to notify CCMH of any changes to the information provided in this form including address, telephone number and/or income.

_____ _____

Responsible Party Signature Date

_____ _____

Witness Date

Questions concerning your application? Please note below. Thank you!

_____

_____

_____

_____

_____

_____

Responsible Party Name: _____

Monthly Income:

- **Guarantor's Gross Income:** _____
- **Spouse's Gross Income:** _____
- **Other Income:** _____

Total Family Income: _____

Family Size:

Current Charity Care Guidelines – net monthly income eligibility standards

	Family Size (Monthly Income)							
Discount	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	$1,012	$1,372	$1,732	$2,092	$2,452	$2,812	$3,172	$3,532
90%	$1,113	$1,509	$1,905	$2,301	$2,697	$3,093	$3,489	$3,885
80%	$1,224	$1,660	$2,095	$2,531	$2,967	$3,402	$3,838	$4,273
70%	$1,347	$1,826	$2,305	$2,784	$3,263	$3,742	$4,221	$4,701
60%	$1,481	$2,008	$2,535	$3,062	$3,589	$4,117	$4,644	$5,171
50%	$1,629	$2,209	$2,789	$3,369	$3,948	$4,528	$5,108	$5,688
40%	$1,792	$2,430	$3,068	$3,706	$4,343	$4,981	$5,619	$6,257
30%	$1,971	$2,673	$3,375	$4,076	$4,778	$5,479	$6,181	$6,882
20%	$2,169	$2,940	$3,712	$4,484	$5,255	$6,027	$6,799	$7,570
10%	$2,385	$3,234	$4,083	$4,932	$5,781	$6,630	$7,479	$8,327

*** 100% discount is based on 2018 Federal Poverty Guidelines***