NORTON HEALTHCARE APPLICATION FOR FINANCIAL ASSISTANCE

ACCOUNT #: ______________________________

PATIENT NAME: ______________________________ DOB: ____/____/____ SSN: ____________________

ADDRESS: ______________________________ HOME PHONE: ______________ MOBILE PHONE: ______________

CITY: ______________ STATE: ______ ZIP CODE: ________ EMAIL: ______________________________

IS PATIENT A US CITIZEN? YES NO IS PATIENT A LEGAL US RESIDENT? YES NO

PATIENT'S EMPLOYER (IF MINOR, PARENT'S INFO): ______________________________ PHONE: ______________

SPOUSE'S EMPLOYER (IF MINOR, PARENT'S INFO): ______________________________ PHONE: ______________

IF YOU HAVE HEALTH INSURANCE, PLEASE PROVIDE:

COMPANY NAME: ____________________ COMPANY PHONE: ____________________

POLICY #: ____________________ POLICY HOLDER: ____________________

WAS THIS STAY DUE TO CAR ACCIDENT? YES NO IF YES, DATE OF ACCIDENT: ______________

ATTORNEY INFORMATION: ______________________________

IS ACCOUNT RELATED TO WORKER'S COMPENSATION? YES NO INJURY DATE: ______________

ATTORNEY INFORMATION: ______________________________

LIST THE NAME, AGE AND RELATIONSHIP OF MEMBERS IN HOUSEHOLD TO THE PATIENT:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

(IF YOU NEED ADDITIONAL SPACE, PLEASE WRITE ON THE BACK OF THIS PAGE)

INCOME (MONTHLY):

PATIENT'S GROSS INCOME (IF PATIENT IS A MINOR, MOM'S MONTHLY INCOME): $ ______________

SPOUSE'S GROSS INCOME (IF PATIENT IS A MINOR, DAD'S MONTHLY INCOME): $ ______________

IF YOU HAVE NO INCOME, WHO PAYS FOR YOUR EXPENSES? ______________________________

K-TAP: $ __________ UNEMPLOYMENT: $ __________

CHILD SUPPORT / ALIMONY: $ __________ FOOD STAMPS: $ __________

SOCIAL SECURITY: $ __________ PENSION: $ __________

SSI / DISABILITY: $ __________ OTHER INCOME: $ __________

- **TOTAL MONTHLY GROSS INCOME: $** __________

EXPENSES (MONTHLY):

RENT / MORTGAGE: $ __________ FOOD AND SUPPLIES: $ __________

TELEPHONE: $ __________ UTILITIES: $ __________

OTHER EXPENSES: $ __________

- **TOTAL MONTHLY EXPENSES: $** __________

COUNTABLE RESOURCES:

	BANK		VALUE
CHECKING:	______		______
SAVINGS:	______		______
MONEY MARKET:	______		______
MUTUAL FUNDS:	______		______
STOCKS:	401k ______	403B ______	______
BONDS:	______	IRA ______	______
OTHER RESOURCES:	______		______

➢ **TOTAL RESOURCES: $** ______

PROPERTY:

HOME:	**OTHER PROPERTY:**
______ MORTGAGEE NAME	______ MORTGAGEE NAME
______ CURRENT VALUE	______ CURRENT VALUE
______ CURRENT EQUITY	______ CURRENT EQUITY (CURRENT VALUE MINUS WHAT YOU OWE)

OTHER HOMES? ______
(IF YES, PLEASE PROVIDE MORTAGEE NAME, ADDRESS, CURRENT VALUE AND CURRENT EQUITY)

THIS CERTIFIES THAT I REQUEST TO BE CONSIDERED FOR FINANCIAL ASSISTANCE AT NORTON HEALTHCARE

I HEREBY AGREE to furnish Norton Healthcare with the information necessary to determine my eligibility for assistance with the medical bills resulting from the services I have received at their facilities. . I understand that my physicians and other health care providers may have financial assistance policies that could assist me with the medical bills from those providers. As such, I authorize Norton Healthcare to provide a copy of my application to those providers who request it to assist them in determining whether I qualify for benefits under their financial assistance programs.

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 information in applying for assistance, my application will be denied and Norton Healthcare will continue to pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify Norton Healthcare of any changes to the information provided in this form including address, telephone number, and income.

______ RESPONSIBLE PARTY SIGNATURE ______ DATE

➢ **PLEASE RETURN THE COMPLETED APPLICATION WITH A COPY OF YOUR LAST 3 MONTHS OF BANK STATEMENTS FOR ALL CHECKING AND SAVINGS ACCOUNTS.**

RETURN INFORMATION TO:

NORTON HEALTHCARE
SBO FINANCIAL ASSISTANCE DEPT 14-7
PO BOX 35070
LOUISVILLE, KY 40232-9972

CUSTOMER SERVICE PHONE #:	(502) 479-6300
FINANCIAL ASSISTANCE FAX #:	(502) 629-8883
E-MAIL ADDRESS:	FAP@nortonhealthcare.org
FOR MORE INFORMATION VISIT:	www.nortonhealthcare.com/FAP