Medical Record # if known _____

HealthCare
The Power of Advanced Medicine

Thank you for choosing UK HealthCare for your healthcare needs.

UK HealthCare is proud of its long history of providing healthcare services to the Commonwealth of Kentucky. Our financial assistance program relieves the financial burden of medically necessary health care. It is available to patients and families with a household income at or below 300% of the Federal Poverty Guideline for your family size. We are pleased to provide you with this application to determine if you meet the qualifications for assistance with your medical services at UK HealthCare.

We require you to complete the enclosed application and provide all required supporting documents to determine your eligibility. All pages of the supporting documents must have the applicant's name and date of birth on the top of each document. If the patient's medical record number is available, include that information along with the name and date of birth. Return the signed, the completed application and the supporting documents via USPS upload through My UKHC Chart at https://ukhealthcare.uky.edu/mychart, or submit by secure fax to 859-257-8071. **Failure to return a completed application within 21 days of the application date with all supporting documentation, including name and date of birth on each document may delay a decision or result in a denial of the application. Note:** Applicants who are eligible for Medicaid, must apply before we can consider the request for financial assistance. During the application process, all normal billing operations will continue.

Disclaimer for Financial Assistance

Approval of financial assistance does not guarantee coverage for all services; all services are subject to the terms, conditions, limitations, and exclusions of the financial assistance policy. If approved, adjustments will only be applied to those accounts within the policy parameters.

Required Documents

- ☐ **Completed and signed Financial Assistance Application**
- ☐ **Proof of gross income and bank account balances for each member of the household OR proof of no income. Gross income is the income before taxes, insurance, and any other deductions.**

Please do not send the original documents, as we may be unable to return them. All financial records after electronic imaging in our secure electronic health system and any unidentifiable required documentation are destroyed. We make every effort to identify each document we receive. To avoid destroying your documentation without attaching it to your application, record the patient's identifiable information on each documentation sheet by putting the patient's name and date of birth. If you have questions or need assistance, call our convenient call line at 859-323-9898 Monday-Friday, 8 AM-4:30 PM. Thank you for choosing UK HealthCare for your medical needs.

2024 Federal Poverty Guidelines

Financial support depends of where the household income falls within this chart.
Please call or contact us through MyChart for screening eligibility.

	Medicaid Limit for Adults Traditional Medicaid	Expanded Medicaid Limit For Adults	Medicaid Limit for Children & Pregnancy	UK Financial Assistance Program
Household Size	**0%-100% FPL**	**101%-138% FPL**	**Up to 200% FPL**	**Up to 300% FPL**
1	$15,060.00	$20,783.00	$30,120.00	$45,180.00
2	$20,440.00	$28,207.00	$40,880.00	$61,320.00
3	$25,820.00	$35,632.00	$51,640.00	$77,460.00
4	$31,200.00	$43,056.00	$62,400.00	$93,600.00
5	$36,580.00	$50,480.00	$73,160.00	$109,740.00
6	$41,960.00	$57,905.00	$83,920.00	$125,880.00
7	$47,340.00	$65,329.00	$94,680.00	$142,020.00
8	$52,720.00	$72,754.00	$105,440.00	$158,160.00

University of Kentucky●Patient Financial Experience Department●1000 South Limestone Room A101●Lexington, KY 40536
Phone: 855-211-4707●Fax: 859-257-8071

HealthCare
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UKHC Financial Assistance Application

Medical Record # if known _____

INSTRUCTIONS: PLEASE RESPOND TO ALL QUESTIONS. LEAVE NOTHING BLANK. IF IT DOES NOT APPLY, ENTER "NONE". YOU WILL BE ASKED TO PROVIDE APPLICABLE DOCUMENTATION THROUGHOUT THE APPLICATION. MAKE SURE YOU VERIFY DOCUMENTS TO SEND. PLEASE SEND COPIES ONLY. NO STAPLES.

I. PATIENT INFORMATION

Patient Name:_____ **Date of Birth:**_____

Address: _____ Social Security Number:_____

City:_____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Are you a KY resident? ☐ Yes ☐ No

Are you in the United States on a Visa, expired or not? ☐ Yes ☐ No ***if yes please provide a copy of the Visa*

Employment Status: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Phone number: _____

Are you considered? ☐ Blind ☐ Disabled ☐ Over the age of 65 ☐ Pregnant ☐ Minor child or ☐ Have minor children in the home? ☐ N/A

II. SPOUSE-If Married ☐ /Parents(s)or Legal Guardian(s)-if patient is a minor ☐/ Not applicable ☐

Name:_____ **Date of Birth**:_____

UKHC MR# _____ Social Security Number:_____ Phone# _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Phone number: _____

Name:_____ **Date of Birth**:_____

UKHC MR# _____ Social Security Number:_____ Phone# _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Phone number: _____

III. Household Members and Income – Provide paycheck stubs/proof of income for the previous month starting with yourself and including all household members. Examples of Income types; Employment Income, Employment Pension, Social Security, Social Security Disability, Welfare Income, Unemployment Compensation, Guard/Reserve Military, Workers Compensation Benefits, Rental Income, Alimony, Interest/Dividends, Grants/Financial Aid/Scholarships

Name of Household Member	Age/Birthdate	Relationship to Patient	Source/Type of Income & Amount 1	Source/Type of Income & Amount 2	Source/Type of Income & Amount 3
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

The household is requested to provide copies of all bank statements for checking, savings, and/or money market accounts for the previous three (3) months OR complete the Attested Statement of No Bank Account.

	Bank Name	Balance
Checking Accounts	_____	$_____
Savings Accounts	_____	$_____
Trust Funds	_____	$_____
Stocks/bonds	_____	$_____
Money Market Accounts	_____	$_____
Mutual Funds	_____	$_____
SSI/SSDI/Social Security Debit Card	_____	$_____

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Patient Name: _____ **Date of Birth: _____**

Complete the Attestation Statement below for patients or households without a checking, savings, Direct Express, or Prepaid card account. Also, households must provide one month of receipts for using a check cashing service or paying utility bills in cash.

Attested Statement of No Bank Account(checking, savings, or debit cards for deposits-only accounts)
This signed and attested statement document is used to verify _____(Applicant Name) does not have a checking or savings account with any financial institution.

_____ _____
Patient or Legal Representative Date

_____
Relationship to Patient

Disclaimer for Financial Assistance
Approval of financial assistance does not guarantee coverage for services; all services are subject to the terms, conditions, limitations, and exclusions of the financial assistance policy. If approved, adjustments will only be applied to those accounts within the policy parameters, and services that are not considered an exclusion.

I certify by signing below that the information provided on this application is true, correct, and complete to the best of my knowledge. I understand false or withheld information will result in revocation of any financial assistance adjustments and charges will become the responsibility of the patient/guarantor.

_____ _____
Patient or Legal Representative **Date**

_____
Relationship to Patient

For Office Use Only: UK HealthCare Employee: _____

Interpreter/CryaCom Representative Name or ID# _____

Patient MRN# _____
Additional Household Members:
1. Name_____ MRN#_____
2. Name_____ MRN#_____
3. Name_____ MRN#_____
4. Name_____ MRN#_____
5. Name_____ MRN#_____
6. Name_____ MRN#_____

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