NORTON HEALTHCARE

Financial Assistance Application Requirements

Thank you for your interest in Norton Healthcare's Financial Assistance Program. Our program is designed to financially support the medical needs of those who qualify.

To determine your eligibility, we must receive a fully completed Financial Assistance Application along with all required supporting documentation.

Required documentation

Please submit the following:

- A fully completed Financial Assistance Application that is **signed and dated.**
- **Three (3) months of bank statements** for **all bank accounts** held by members of the household. Statements must include all pages, even if a page is blank.

Our goal is to process your application as quickly as possible. Providing all required information at the time of submission will help us expedite our review and avoid unnecessary delays.

If you have any questions regarding the application process or documentation requirements, please call our Customer Service team at **(502)-479-6300**. We are happy to assist you.

Thank you for your cooperation and for allowing us the opportunity to serve you.

Sincerely,

Norton Healthcare Financial Assistance Team

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:

_____
MORTGAGEE NAME

_____
CURRENT VALUE

_____
CURRENT EQUITY

OTHER PROPERTY:

_____
MORTGAGEE NAME

_____
CURRENT VALUE

_____
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 719046
CHICAGO, IL 60677-7046

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