All disputed debt payments, "Paid in Full" payments and communications must be sent to the following address:

Norton Healthcare
Patient Financial Services 14-7
Disputed Payment Department
P. O. Box 35070
Louisville, KY 40232-5070

APPLICATION FOR FINANCIAL ASSISTANCE - MINOR SERVICES

Norton Healthcare Financial Assistance Application for Minor Services Only

Patient Name: ______________________________ **SSN#** ______________________ **DOB** ________________
Spouse's Name: ______________________________ **SSN#** ______________________ **DOB** ________________
Address ____ **PHONE** ______________
Family Size: Number in Household: ______________________ **Number of Dependents**: ____________________
Income: Total Gross Income for Household: Monthly $________________ **or Yearly** ________________
Income includes: Patient income, Spouse's income, Child Support/Alimony, Monthly Social Security Checks, Pension, Unemployment, SSI, or Disability Includes ANY other income
Resources: Amount in Checking $ ____________ **Amount in Savings $**___________
Stocks/Bond/CD's Value (even if unable to be cashed in) __________ 403B ________; 401K _______, Other _____
Assets: Total Value of Assets $ _______________excluding the home that you currently reside
Assets include any additional property, land, additional rental homes, etc.

This certifies that I request to be considered for financial assistance at Norton Healthcare. 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 pursue collection of any outstanding balance due. I understand that the application being completed is only for minor hospital services. Eligibility consideration for major hospital services will require the completion of the full Norton Healthcare Application for Financial Assistance and may require additional information and proof of income/resources be submitted to determine my eligibility for assistance with those additional major services.

______________________________ ______________ ____________________ __________
Responsible Party Signature Date Witness Signature Date

RETURN INFORMATION TO:
NORTON HEALTHCARE
SBO FINANCIAL ASSISTANCE DEPT 14.7
P.O. BOX 35070
LOUISVILLE, KENTUCKY 40232-9972

EMAIL TO: FAP@nortonhealthcare.org

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