# 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, MOM'S INFO): _____ PHONE: _____

SPOUSE'S EMPLOYER (IF MINOR, DAD'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 GROSS INCOME): $ _____

SPOUSE'S GROSS INCOME (IF PATIENT IS A MINOR, DAD'S MONTHLY GROSS 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 FAMILY UNIT INCOME:** | **$** _____ |

**HOUSEHOLD 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:** | **AUTO #1:** | **AUTO #2:** |
|---|---|---|---|
| MORTGAGEE NAME | MORTGAGEE NAME | YEAR/MAKE/MODE | YEAR/MAKE/MODEL |
| CURRENT VALUE | CURRENT VALUE | CURRENT VALUE | CURRENT VALUE |
| CURRENT EQUITY | CURRENT EQUITY (CURRENT VALUE MINUS WHAT YOU OWE) | CURRENT EQUITY (CURRENT VALUE MINUS WHAT YOU OWE) | CURRENT EQUITY (CURRENT VALUE MINUS WHAT YOU OWE) |

**OTHER HOMES?** _____

(IF YES, PLEASE PROVIDE MORTAGEE NAME, ADDRESS, CURRENT VALUE AND CURRENT EQUITY)

**OTHER AUTOS?** _____

(IF YES, PLEASE PROVIDE YEAR, MAKE MODEL, OWNER, CURRENT VALUE AND CURRENT EQUITY)

**OTHER PROPERTIES (ATV, MOTORCYCLE, MOTORHOME, ETC.)?** _____

(IF YES, PLEASE PROVIDE YEAR, MAKE, 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 PROVIDE _____ FEDERAL TAX RETURN (FORM 1040) AND 2 MONTH'S PAYCHECK STUBS, AND PROOF OF SSI, SOCIAL SECURITY, AND/OR PENSION (WHERE APPLICABLE) WITH COMPLETED APPLICATION. IF YOU ARE NOT REQUIRED TO FILE TAXES, PLEASE PROVIDE 2 RECENT BANK STATEMENTS.**

**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