NORTON HEALTHCARE

EXHIBIT B2 - 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

E-MAIL TO: FAP@nortonhealthcare.org

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