MONROE COUNTY MEDICAL CENTER

Financial Assistance Application Instructions

At the Monroe County Medical Center, financial assistance for eligible charges is available to anyone for eligible services who meets the eligibility requirements for total household income, total patient assets and then furnishes documentation to confirm this information.

A completed financial assistance application and proof of income must be submitted in order for us to consider a financial need discount and/or full financial assistance. Once we receive your completed application we may assess whether or not you qualify for state or other financial assistance programs. If this assessment determines you do not qualify for these programs we will evaluate your financial assistance application to determine if you qualify for a financial need discount or full financial assistance. Those who qualify may receive assistance with their hospital bills.

IMPORTANT INFORMATION REQUIRED WITH APPLICATION

Proof of Income (POI): Please provide the following information or an explanation as to why this information is not available. Missing documentation may delay the processing of your application and could result in a denial for assistance.

Below is a listing of the POI documentation that is required for consideration fo MCMC Financial Assistance.	
Type of Income	**Required documentation**
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year • Copy of two most recent paystubs
Self-Employment	• Copy of Individual tax return (Form 1040) for current tax year
Social Security/Retirement	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from Social Security Administration stating monthly payment • Copy of monthly payment notification from Social Security Administration
Disability	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from disability stating monthly disability payment • Copy of monthly payment notification from disability
Unemployment	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from unemployment stating weekly or monthly benefit amount • Copy of monthly payment notification from unemployment
Rental Property	• Copy of Individual tax return (Form 1040) for current tax year
Investment Income	• Copy of Individual tax return (Form 1040) for current tax year
Proof of Dependents	• Copy of Individual tax return (Form 1040) for current tax year

Every reasonable effort will be made to process your application promptly and, once your application has been reviewed, you will receive a letter confirming the outcome. Completed applications may be mailed with the required supporting documentation to the address listed below:

Monroe County Medical Center
Attention: Patient Financial Counselor
529 Capp Harlan Road
Tompkinsville, Kentucky 42167

Applications may also be faxed to (270) 487-0891

MONROE COUNTY MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

1. PATIENT(S) INFORMATION (PLEASE PROVIDE NAMES OF ALL PATIENTS TO BE CONSIDERED FOR FINANCIAL ASSISTANCE) -PLEASE PRINT ALL INFORMATION-

Last Name	First Name	Middle Initial	Relationship

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.

2. APPLICANT (GUARANTOR) INFORMATION

RELATIONSHIP TO PATIENT

- ☐ Self
- ☐ Spouse/Domestic partner
- ☐ Parent
- ☐ Other

MARITAL STATUS

- ☐ Single
- ☐ Married/Domestic Partner
- ☐ Divorced
- ☐ Separated

If you marked YES to married or domestic partner: please complete Section 3

Last Name First Name M.I.			U.S. Citizen ☐ Yes ☐ No
Date of Birth	No. of Dependents (Other than applicant & co-applicant)	Ages of Dependents	Home Phone ( )
Street Address (Do not list P.O. Box)	City	State	County / Zip
Current Employer	Street Address, City, State		Position

- If you are not working, how long have you been unemployed?

3. CO-APPLICANT (GUARANTOR) INFORMATION

RELATIONSHIP TO PATIENT ☐ Spouse/domestic Partner ☐ Parent ☐ Other

Last Name First Name M.I.			U.S. Citizen ☐ Yes ☐ No
Date of Birth	No. Of Dependents (Don't include those claimed by co-applicant)	Ages of Dependents	Home Phone ( )
Street Address	City	State	County / Zip
Current Employer	Street Address, City, State		Position

- If you are not working, how long have you been unemployed?

4. OTHER COVERAGE QUESTIONS: -- (All answers pertain to the patient)

1.	Does the patient have health insurance? If yes, please provide the following information: Health Insurance Name: _____ Subscriber Name: _____ Members/Patients Identification Number: _____ Group Number: _____ Group/Employer Name: _____ Effective Date: _____ Health Insurance Telephone Number: _____	☐ Yes ☐ No
2.	Is the patient eligible for a state medical assistance program? If yes, please provide the following information: Name of program: _____ County: _____ Patient Identification Number: _____	☐ Yes ☐ No
3.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Cork Comp Carrier: _____ Adjusters Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
4.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? Is yes, please provide the following information: Name of auto insurance or attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐ Yes ☐ No
5.	Is the patient a Victim of Crime? If yes, please provide the following information: Date of injury? _____ Name of Case Worker: _____ Case Worker's Phone Number: Case Worker:	☐ Yes ☐ No

5. INCOME INFORMATION

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income (Applicant + Co-Applicant)
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other	$	$	$
		Total Combined Monthly Income	$

6. IF YOU DO NOT HAVE MONTHLY INCOME, PLEASE EXPLAIN HOW YOU TAKE CARE OF YOUR MONTHLY EXPENSES. USE ADDITIONAL PAGES IF NECESSARY

7. SIGNATURE

I certify that all information is valid and complete and hereby authorize Monroe County Medical Center to request and /or verify any of the above information as deemed necessary.

Applicant _____ Date _____ Co-Applicant _____ Date _____

Return completed application to:

Monroe County Medical Center
Patient Financial Services
529 Capp Harlan Road
Tompkinsville, KY 42167

or Fax to (270)487-0891