CCH
CUMBERLAND COUNTY HOSPITAL
P.O. Box 280, 299 Glasgow Rd. Burkesville, KY 42717 — 270-864-2511

Dear Patient:

Cumberland County Hospital understands that hospital medical care can create unexpected financial hardships for patients and their families.

Cumberland County Hospital offers several financial assistance programs designed to help relieve this financial burden. Please contact Kim Jordan in the business office Monday through Friday from 8:00 a.m. to 4:00 p.m. at (270) 864-2511, ext. 1349, to see if you qualify for one of the financial assistance programs. You will need to have your household income information available when you call.

If you would like to apply for assistance, please fill out the attached application and mail it to the hospital in the self-addressed envelope included. Please note that any charges that pertain to the Doctors fees, Ambulance fees or any outside Radiology fees will not be considered with this application. Those fees will be the responsibility of the patient effective July 1, 2010.

In order to check for program eligibility, we need verification of all income for all household members, a copy of your most recent bank statement, and a Medicaid denial letter from within the last 30 days only if you do not currently have Kentucky Medicaid. The best source of income would be a copy of your current federal tax return, copies of check stubs for all household members, or copy of your award letter. If you are not employed, then you must have two people not related to sign the income verification form attached.

Also please note that while your application is under review, you will continue to receive statements and if they remain unpaid, this account may advance to a collection agency.

Thank you for choosing Cumberland County Hospital for all your healthcare needs.

Sincerely,

Patient Financial Services

Today's Date:_____

Cumberland County Hospital

Charity Assistance Program Application

General Information

1. Patient's Name:_____
2. Street Address:_____
3. City:_____ State: KENTUCKY Zip Code:_____
4. Social Security Number:_____
5. Date of Birth:_____ 6. Patient's Sex: **M / F**
7. Home Phone:_____ 8. Cell Phone:_____
9. Marital Status**: Married / Single** 10. Name of Spouse:_____
11. List the name, relationship, and age of each person living in the household including yourself.

(Do not list anyone who you do not claim on your Federal Income Tax)

Household Member's Name	Relationship	Age

Income Information

12. Patient Employer:_____ City/State:_____, KENTUCKY
13. Total Gross Monthly Income:_____ 14. Work Phone:_____
15. Spouse Employer:_____ City/State:_____, KENTUCKY
16. Total Gross Monthly Income:_____ 17. Work Phone:_____

Other Income:

Unemployment:_____ Child Support:_____

Social Security:_____ Workers Comp:_____

Pension/401K:_____ Other:_____

17. Total Family Unit Gross Monthly Income:_____

Today's Date:_____

I hereby agree to furnish Cumberland County Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that Cumberland County Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within thirty (30) working days is grounds for denial of my application for assistance. I also agree to notify Cumberland County Hospital of any change of address, phone number, employment status, or income.

I agree to allow the Cumberland County Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP, and DSH.

I clarify that the information provided on this application is correct to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact Cumberland County Hospital to make a hearing request.

_____ _____

Individual or Responsible Party's Signature Date

_____ _____

Hospital Employee Signature Date

_____ _____

Hospital Supervisor Approval Date

ITEMS NEEDED FOR CHARITY:

- TURN IN COMPLETED APPLICATION
- MOST RECENT BANK STATEMENT
- PROOF OF INCOME (i.e. PAY STUB, AWARD LETTER, OR COPY OF INCOME TAXES)

  ** (BANK STATEMENT WILL NOT WORK AS PROOF OF INCOME) **
- MEDICAID DENIAL LETTER *ONLY if you do not currently have Medicaid* (When you turn this letter in it must be within the last 30 days. This means if you were denied on Nov. 1st you must bring this letter in before Dec. 1st for it to be valid. If you do not turn it in with in the 30 days you will have to go re-apply for Medicaid to receive a new denial letter.)

** ALL ITEMS MUST BE TURNED IN TO QUALIFY **