ROCKCASTLE REGIONAL
HOSPITAL ▪ RESPIRATORY CARE CENTER

Dear Patient:

Thank you for choosing Rockcastle Regional Hospital for your healthcare needs. We are pleased to provide you with this application to help determine if you meet the qualifications for assistance with your hospital bill. In order for us to process your application for participation with the **Financial Assistance Program (FAP)**, the information requested on the FAP must be completed in its entirety.

In processing the FAP application, we are required to verify your income. Proof of income examples are as follows:

Check stubs for the last 30 days
Social Security awards letter or a copy of bank deposit showing Social Security deposit
Written verification of wages from employer for the last 30 days
Written verification from public assistance summarizing benefits
Workers Compensation checks/awards letter
Unemployment checks/awards letter
W-2
Copy of 1040 federal income tax return

If you have no income, acceptable verification of no income is a written statement of no income signed by three witnesses. Please return proof of income or proof of no income with the attached FAP application.

If you would like assistance in completing the FAP application, or have any questions regarding the application process, please do not hesitate to contact the **Business Office at (606) 256-2195, Extension 7701**. We can be reached Monday-Friday, 8am-4pm.

Please return application to: Rockcastle Regional Hospital
PO Box 1310
Mount Vernon, KY 40456
Attn: Patient Accounting

If you are approved for the FAP Program please keep in mind that it covers medically necessary Hospital services only. The FAP program does not cover Emergency Room Physician or Radiologist charges; you will receive a separate bill from TeamHealth or South Central Radiology. A complete listing of non-covered Providers is available upon request in the Emergency Department and admission areas of the hospital. You may also access these documents online at http://rockcastleregional.org/financial-services/.

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FINANCIAL ASSISTANCE APPLICATION

PATIENT DEMOGRAPHICS

PATIENT NAME: LAST, FIRST, MIDDLE	SOCIAL SECURITY #:	DATE OF BIRTH:	ACCOUNT #:
GUARANTOR NAME: LAST, FIRST, MIDDLE	SOCIAL SECURITY #:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
PATIENT/GUARANTOR ADDRESS:	COUNTY	HOME PHONE #	ALTERNATE PHONE #
CITY	STATE	ZIP CODE	HOMEOWNER YES OR NO
Have you applied for Medicaid or any other State/County Assistance? (circle one) YES NO If yes, please provide the following:			
Application date: Caseworker name:		Status of Application: Caseworker Phone Number:	

HOUSEHOLD INFORMATION

Marital Status: (Please circle one) Married Single Separated Divorced Widowed		
Dependent Names:	Relationship:	Date of Birth:

EMPLOYMENT/HOUSEHOLD INCOME AND EXPENSES

Patient/Guarantor Employer Name	Gross Monthly Income:	PROVIDE VERIFICATION
If income is $0, please explain:		PROVIDE DOCUMENTAITON
Spouse's Employer Name:	Gross Monthly Income:	PROVIDE VERIFICATION
If income is $0, please explain:		PROVIDE DOCUMENTAITON
Other Income Source:	Gross Monthly Income:	PROVIDE VERIFICATION

IMPORTANT: To qualify for assistance, at least one piece of supporting documentation to verify household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, one month of current pay-stubs, signed letter of support, etc. Please also provide a copy of identification for verification, as well as proof of Medicaid denial if applicable.

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach income verification.

I certify that the information I have provided is true and accurate to the best of my knowledge.

I will independently or with hospital assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, or local government to help pay this healthcare bill.

I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.

I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.

I understand that additional information may be requested in order to qualify for assistance.

Signature of Applicant/Guarantor:	**Date:**

RETURN COMPLETED APPLICATION AND DOCUMENTS TO:

Rockcastle Regional Hospital
Attn: Patient Accounting
PO Box 1310
Mt. Vernon, KY 40456

Phone: (606) 256-2195
Fax: (606) 256-3947