Dear Valued KDMC Patient:

King's Daughters offers financial Assistance to cover the out-of-pocket expenses for qualifying patients. Eligibility for assistance depends on your prompt return of the application and the Income Verification Information listed below. You may also be asked to complete applications and provide information for other programs which are offered by local, state or federal agencies. Refusal to respond to these requests may affect the status of this application.

Income Verification Information

Send all of the information below that applies to you, or any other member of your household.

- Pay check stubs for the past three (3) months, or the most recent one (1) which provides year-to-date earnings, or a letter from your employer to verify your gross income.
- Verification of Social Security, Disability or Workers' Compensation benefits
- Verification of Unemployment, Retirement or Pension benefits
- Verification of Self-employment status and income
- Verification of Child Support or Alimony payments
- A copy of **ALL** forms filed with your Federal Income Taxes for the previous year, including W2s
- Bank statements (checking and savings) for the past three (3) months, including all numbered pages, even if blank
- **No Income Verification Form** completed by the person providing for your living expenses, ONLY if neither you nor your spouse have any source of income
- **Statement of Separation Form** completed by a non-relative who can testify that you and your spouse are currently separated and maintaining separate households

If you have any questions, would like to schedule an appointment or need to return your completed application and verification information, you may contact us by the following methods:

By Phone: 606-408-4118 or 866-408-6466
By Fax: 606-408-6917
By E-mail: FinancialAssistanceTeam@kdmc.kdhs.us

By Mail: King's Daughters Medical Center
Attn: Financial Counselors
PO Box 151
Ashland, KY 41105

Please, allow adequate time for the processing of your completed application. After processing is complete, you will receive a letter to explain your approval or the reason for denial.

Sincerely,

King's Daughters
Financial Resource Center

FINANCIAL ASSISTANCE APPLICATION

KING'S DAUGHTERS

PATIENT or
RESPONSIBLE PARTY: _____ **SSN:** _____ **DOB: (/ /)**

ADDRESS: _____ **CITY, STATE & ZIP:** _____

E-MAIL: _____ **MARITAL STATUS:** _____

PHONE NUMBERS: (HOME) _____ **(WORK)** _____ **(CELL)** _____

List any other members of your immediate household (spouse; minor, dependent children; or full-time students over 18 years old)

Spouse's Name: _____ SSN: _____ DOB: (/ /)

Child/Dependent: _____ SSN: _____ DOB: (/ /)

Child/Dependent: _____ SSN: _____ DOB: (/ /)

Child/Dependent: _____ SSN: _____ DOB: (/ /)

SOURCE OF HOUSEHOLD INCOME: Answer the following questions for you, your spouse and dependents in your household.

	PATIENT	SPOUSE	DEPENDENT
Are you currently working, or have you worked within the past six (6) months?	YES NO	YES NO	YES NO
Are you receiving Unemployment or Workers' Compensation benefits?	YES NO	YES NO	YES NO
Are you receiving Social Security, Veteran's Administration or Disability benefits?	YES NO	YES NO	YES NO
Are you receiving a Pension or Retirement benefits?	YES NO	YES NO	YES NO
Are you receiving Alimony, Child Support or Kinship benefits?	YES NO	YES NO	YES NO
Do you receive any form of Rental Income?	YES NO	YES NO	YES NO
Do you receive any form of income assistance from the State?	YES NO	YES NO	YES NO

Resources: Provide the current estimated value of each of your resources.

Checking account	$	Savings account	$
Certificate of Deposit (CDs)	$	Stocks	$
Savings Bonds	$	Annuities	$
401k (or similar account)	$	Checking account:	$

How many cars are owned by you, your spouse and dependents? _____ What is the total estimated value? _____

Do you own any **REAL ESTATE** other than your home? YES NO

If YES, provide a short description and estimated value: _____

_____

Is the reason for your visited related to an illness, injury or condition that is due to the negligence of another person? YES NO

If YES, provide an explanation: _____

_____

I understand and agree that the information in this form will be relied upon in determining my eligibility for financial assistance and that incorrect, incomplete or misleading information may result in the denial or rescission of financial assistance. I further understand and agree that I have a duty to supplement the information contained in this form in the event a material change in my financial circumstances takes place prior to the final determination of my eligibility for financial assistance.

Applicant's Signature: _____ Date: _____