Ephraim McDowell Health

EXHIBIT B

FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

1. Complete the financial assistance application.
2. Include all monthly income and expenses in the spaces provided.
3. Provide proof of income, including:
   a) Last 2 pay stubs OR most recent filed W-2;
   b) Most recent bank statements;
   c) Most recent tax returns;
   d) Benefit awards letters or 1099 forms showing Social Security, Disability, Worker's Compensation, or Veteran's Administration benefits;
   e) Copies of benefit award letters or 1099 forms showing Unemployment, Retirement*, or Pension benefits;
   f) Proof of Assets which may include, but not limited to checking, savings, investments, holdings, and retirement accounts for most recent three months;
   g) Verification of self-employment status and income received:
      (1) Receipts from clients,
      (2) Signed Federal income taxes from the most recent filing year which include the appropriate schedule showing income from self-employment, S-corp, or other such entity.
4. Provide copy of Medicaid denial letter.
5. Sign the financial assistance application.

If you have no income, you will need to provide an explanation of how you meet your daily living expenses.

*If you have questions or need assistance completing this application, please call (859) 239-2333. Or visit a Financial Counselor located at 217 South Third Street, Danville, KY 40422, Monday through Friday, 8:00am to 5:00pm.

Mail the completed application and documents to:
Ephraim McDowell Health, Inc.
217 South Third Street
Danville, KY 40422
ATTN: Financial Counselor

Once we have received all of the information and documentation requested, we will make a determination and notify you by mail of your eligibility for participation in the Financial Assistance Program within 30 days.

Ephraim McDowell Health

Responsible Party Name: _____ Date of Birth: _____ SSN: _____
Address: _____ Phone: _____
_____ Marital Status: _____
Spouse Name: _____ Spouse Date of Birth: _____ Spouse SSN: _____
Primary Insurance: _____ ID #: _____ Insured Person: _____
Secondary Insurance: _____ ID #: _____ Insured Person: _____

Household Member's Name	**Relationship**	**SSN**	**Age**

(Use back of page for additional Household Members) Number of people in the household (including patient) _____

EMPLOYMENT:
Employer: _____ Length of Employment or Hire Date: _____
Spouse Employer: _____ Spouse Length of Employment or Hire Date: _____

GROSS INCOME:	Monthly ($)
Responsible party or patient's gross wages from paychecks/W2s…….	_____
Spouse's and any children's gross wages from paychecks/W2s……	_____
Alimony……..	_____
Social Security……	_____
SSI/Disability/K-Tap……..	_____
Unemployment……	_____
Pension……	_____
Food Stamps……	_____
Other Income (e.g., Investment, Workers' Comp.): Yes/No (circle one) If yes, list: _____	_____
TOTAL MONTHLY INCOME……..	$ _____

EXPENSES:	
Rent/Mortgage…….	_____
Food and Supplies……...	_____
Utilities……	_____
Telephone……	_____
Childcare…….	_____
Insurance Premiums (auto, health, dental, life, home, etc.)……	_____
Prescribed Medications……..…	_____
Other Expenses? Yes/No (circle one) If yes, list: _____	_____
TOTAL MONTHLY EXPENSES……...	$ _____

RESOURCES:	
Checking and Savings Accounts……..	_____
Stocks and Bond Values……....	_____
Real Estate other than primary residence: Value _____ Balance Owed _____	
Other resources? Yes/No (circle one) If yes, list: _____	_____
TOTAL RESOURCES…….	$ _____

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 may be denied and Ephraim McDowell Health may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify EMH of any changes to the information provided in this form including address, Telephone number, and income.

_____ _____
(RESPONSIBLE PARTY SIGNATURE **(DATE)**

_____ _____
(SPOUSE SIGNATURE) **(DATE)**

OFFICE USE ONLY
Discount % Approved _____
Date Submitted _____
FC Signature _____
Approval Signature_____
Date Approved _____

Ephraim McDowell Health

STATEMENT OF INCOME

I understand that intentionally falsifying information regarding my household size and/or income will result in denial. I will be liable for charges of services provided.

Household size _____

Total household income $_____ (monthly)

_____ has ZERO earned income since _____.
Patient Name Date

I certify that the above referenced information is correct to the best of my knowledge.

Signature _____ Date _____

Relationship to Patient _____