Jane Todd Crawford Hospital

Application for Indigent Care, Charity Care, Financial Discount Care Assistance

Responsible Party Name: _____ Date of Birth: _____
SSN: _____ _____ Phone: _____ _____ Marital Status: _____
Address: _____ _____ Spouse Name: _____
_____ Spouse Date of Birth: _____
Spouse SSN: _____
Primary Insurance: _____ ID#: _____ KY resident: (Y) (N)
Secondary Insurance: _____ID#: _____ Patient pregnant: (Y) (N)

Household Member's Name	Relationship	SSN	Age

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

EMPLOYMENT:
Employer _____ Spouse Employer: _____

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:

	Monthly ($)
Rent/Mortgage	_____
Food and Supplies	_____
Utilities	_____
Telephone	_____
Child Care	_____
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 Bonds Values $ _____
Real Estate other than primary residence: Value _____ Balance Owed _____
Other resources? Yes/No (circle one) If yes, list: _____
Have you applied for any Federal, State, or private financial assistance? Yes/No (circle one)
If so, what? (Medicaid, Food Stamps, etc.) _____

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 gave false information or withhold information in applying for assistance, my application may be denied and Jane Todd Crawford Hospital may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify Jane Todd Crawford Hospital of any changes to the information provided in this form including address, telephone number and income.

_____ _____
(Responsible Party Signature) **(Date)**

_____ _____
(Witness/Hospital Employee Signature) **(Date)**