



Financial Assistance Packet

This packet includes information required for the MCCH to determine if you are eligible for financial assistance for dates of service. Please **complete** the enclosed packet, sign all the forms and return to:

Attn: Financial Counselor, MCCH, North Tower, 270-752-2186
or by mail to 803 Poplar Street, Murray, KY 42071

Appendix:

- (A) Financial Assistance Notification Letter
- (B) Eligibility List
- (C) Proof of Income list
- (D) Zero Income Statement
- (E) Financial Screening Sheet
- (F) DSH Application and Medicaid Screening Form
- (G) Financial Assistance Worksheet

MCCH Financial Assistance guidelines state that you have **10 DAYS** to return all needed information or your application may be denied.

Thank you and if you have any questions please see the contact information below.

Vonnie S. Hays Adams
Director of Patient Access
vsadams@murrayhospital.org
270-762-1211

Appendix A

Financial Assistance Notification Letter

Date:

Patient Name:

Patient Address:

Patient Account #:

Date of Service:

Thank you for choosing Murray Calloway County Hospital. I am contacting you about a program we have that offers qualified households assistance with medical expenses. If you qualify, this program will assist you in resolving your outstanding balance with us.

If you are interested in applying for this assistance, please return the enclosed application with copies of all of the required information **within 10 days**. If you wish, you may also call and make an appointment with me to bring the information in to my office located on the second floor of the North Tower. My contact information is below. If I do not hear from you within the 10-day period, I will assume that you do not wish to apply and MCCH will continue with its collection efforts.

I appreciate your immediate attention to this matter.

Sincerely,

Brittany McDaniel
Financial Counselor
Murray-Calloway County Hospital
bjmcdaniel@murrayhospital.org
270-752-2186

Appendix B

Murray-Calloway County Hospital Financial Assistance Policy Eligibility List

In order to be eligible for financial assistance:

1. Applicants must be a citizen of the United States of America and have a Social Security Number. *A student /employment visa issued social security number will not be accepted.*
2. Applicants must be a resident of Calloway County and/or employed in Calloway County. Full-Time/Part-Time Murray State University students who are not permanent residents of Calloway County who have a temporary residence in Calloway County (which is not on-campus/university housing) may also apply. *Applicants must be able to provide proof of residence and employment as applicable.* Applicants may be considered for financial assistance who are not residents of Calloway County and/or not employed in Calloway County if they live in Trigg, Marshall, or Graves County or an Out of state resident if they are referred to MCCH for providers/services that are not available in their county of residence. (i.e., interventional cardiology, oncology, radiation, etc.)
3. Applicants will be screened for eligibility for the Kentucky Medicaid or DSH Programs.
4. **The application must be received by the MCCH Financial Assistance Counselor no later than 6 months (180 days) from the date of service or within three months from the last insurance payment.**
5. The debt in question must only be from MCCH or MCCH affiliates.
6. Applicant cannot be covered by 3rd party payer.

Appendix C

Proofs of Income Policy and Instructions

Proof of income is mandatory for all assistance programs. Acceptable forms must include the following:

1. Copy of most recent tax statement or all W2's for all members of the household. *(2025)*
2. Copy of the year to date pay stub from all working age persons *(18 yrs. of age and older)* within the household. *(Jan. 1, 2026 to present)*

AND/OR

Copy of unemployment check for all applicable household members.

AND/OR

Copy of workers compensation check for all applicable household members.

AND/OR

Copy of pension check for all applicable household members.

AND/OR

Copy of Social Security Income award statement of current benefit for all applicable household members.

AND/OR

Two notarized "Zero Income" statements (*Appendix D*) completed by a non-relative.

3. Two most recent bank statements: For all checking and savings Accounts as applicable for all applicable household members

Appendix D

Zero Income Statement

To whom it may concern:

This is to certify that I, _____ have zero income at this time. The last time I worked was _____ and I made approximately _____ per hour/week.

Signatures: _____

Note: The witnesses must NOT reside in the patient's residence and be non-relatives of the patient.

_____ (Patient Signature) _____ (Date)

_____ (Witness Signature) _____ (Date)

_____ (Witness Address)

**Witness signature verifies that that the information above is complete and accurate to the best of their knowledge.

STATE OF KENTUCKY

COUNTY OF _____

The foregoing document was acknowledged before me this _____ (date)
by _____ & _____ (name of
person(s) acknowledged).

Notary Public

Printed Name: _____

My Commission Expires; _____

Zero Income Statement 1

Appendix D

Zero Income Statement

To whom it may concern:

This is to certify that I, _____ have zero income at this time. The last time I worked was _____ and I made approximately _____ per hour/week.

Signatures: _____

Note: The witnesses must NOT reside in the patient's residence and be non-relatives of the patient.

_____ (Patient Signature) _____ (Date)

_____ (Witness Signature) _____ (Date)

_____ (Witness Address)

**Witness signature verifies that that the information above is complete and accurate to the best of their knowledge.

STATE OF KENTUCKY

COUNTY OF _____

The foregoing document was acknowledged before me this _____ (date)
by _____ & _____ (name of
person(s) acknowledged).

Notary Public

Printed Name: _____

My Commission Expires; _____

Zero Income Statement 2

Appendix E

Murray –Calloway County Hospital Financial Application Financial Screening Sheet

Please complete and mail the information below, along with all of the required documentation listed in Appendix C & D if applicable, to: MCCH Financial Counseling Dept., 803 Poplar Street, Murray, KY 42071 or call, MCCH Financial Counselor at 762-1100 ext. 2186, Monday through Friday from 8:00 a.m. to 3:00 p.m. to set up a time to drop off the packet in person.

Patients cell/home phone number _____

Is the patient: Single Married (please circle one) If separated, how long? _____

Are there minors in the home? Yes No (please circle one) If yes, how many? _____

Are both the mother and father of the minor(s) living in the home? Yes No (please circle one)

Number of minor children in the patient's custody _____

Is the patient disabled? Yes No (please circle one)

Has the patient been deemed disabled by a physician? Yes No (please circle one)

What is the nature of the disability? _____

Has the patient applied for disability benefits from Social Security? Yes No (please circle one)

If so, what was the date the disability application was placed? _____

Has the patient received any denials from the SSA? Yes No (please circle one)

If so, how many? _____

Have you been before a judge to decide on your disability application? Yes No (please circle one)

What is the name and phone number of the attorney representing you on your disability case?

Have you applied for Medicaid? Yes No (please circle one) If so, when? _____

Who is your case worker? _____ Phone # _____

What is the total monthly household income? \$ _____ Annual Household Income \$ _____

Is the patient unemployed? Yes No (please circle one) If so, how long? _____

What is the total household income for the past 12 months? _____

Is the patient unable to work for one month due to this illness or injury? Yes No (please circle one)

Appendix E – Page -2-

Is/was the patient the primary wage earner for the household? Yes No (please circle one)

Within the last 6 months, have you or your spouse carried insurance? Yes No (please circle one)

Does the patient have any health insurance that will cover this visit? Yes No (please circle one)

Name of the policy holder _____ Company name _____

Policy number _____ Company phone number _____

List the balance of any bank, 401k, or IRA accounts _____

List year, make, model or all vehicles in the home: 1st _____,

2nd _____, 3rd _____

What is the amount owed on each of the vehicles? _____

Do you have any stocks, bonds, motorcycles, boats, RV's etc? _____

What is the value of these items? _____

Does the patient have life insurance? Yes No (please circle one) Term or Whole? _____

If whole policy, what is the cash value? _____

Is this visit due to a motor vehicle accident? Yes No (please circle one)

If yes, is there insurance involved? Yes No (please circle one)

(If yes, please complete the insurance information above)

Is the patient pregnant? Yes No (please circle one)

Was this visit due to a crime? Yes No (please circle one)

If yes, were you an innocent victim of a crime? Yes No (please circle one)

Will a police report be filed within 48 hours of the crime? Yes No (please circle one)

Patient employer name and number _____

Household Member employer name and number _____

Total amount of current unpaid medical bills _____

Name and telephone number we have permission to speak with _____

Contact relation to the patient _____

Name of person completing this form (please print) _____

Signature of the person completing this form _____

Your relationship to the patient _____

Appendix F

DSH Application and Medicaid Screening Form

Individual Information

Today's Date:	Work Phone:
Patient's Name:	Dates services were provided: / / - / /
Street Address:	Married/Single:
City:	Name of Spouse:
State: Zip Code:	Is the patient pregnant? Yes No (Circle one)
Social Security Number - -	Is the patient a resident of KY? Yes No Circle One)
Date of Birth: Birth sex:	Email Address:
Home/Cell Phone:	

List the name, social security number, relationship and age of each person living in the household.

Household Members name	Social Security #	Relationship	Age

Does the individual have dependent children living in the home? Yes No (Circle one)

If the answer is **YES**, refer the individual to DCBS for Medicaid.

If the answer is **NO**, refer the individual to DCBS for Medicaid **ONLY IF** the individual has **NOT** received a denial from Medicaid within 30 days.

If the individual, who has no children less than 18 years of age, claims to be disabled, refer the individual to the Social Security Administration to apply for Supplemental Security Income.

Income Information

Patient Employer:	Social Security/SSI:
Spouse Employer:	Workers Comp:
Work Phone	Other:
Total Gross Monthly Income:	Checking Account Balance:
Unemployment:	Savings Account Balance:
Child Support:	<u>Total Family Unit Income:</u>

Certifying Accuracy of Information

I hereby agree to provide all the necessary information to allow MCCH to determine my need to receive financial assistance for health care services received. I agree that the MCCH 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 10 working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status or income.

I agree to allow the hospital representatives to determine eligibility and pursue state and assistance with Medicaid and DSH.

I certify that the information provided on this application is correct to 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 the hospital to make a hearing request.

Individual or Responsible Party Signature

Date

Hospital Employee Signature

Date

Does the individual appear to qualify for Medicaid? Yes No (Circle one)

If yes, then refer the individual to the DCBS office in the county of the individual's residence or

The individual should take a copy of this form with him/her to the DCBS office or to:

*William Longworth, Certified KyConnector
Murray Calloway County Hospital
803 Poplar St
Murray, KY 42071*

*Tel: 270-762-1891
Fax: 270-767-3662*

***William's office is located in the South Tower in the Radiology Department**

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Appendix G

Financial Assistance Worksheet

Patient Name		Patient Account(s) #	
Account balance			
INCOME		MONTHLY EXPENSES	
Applicant		Rent/House payment	
Gross Salary		Food	
Net Salary		Utilities	
		Car Payment	
		Car Insurance	
Other Adult Household Member(s)		Charge Accounts	
Gross Salary		Visa/MC	
Net Salary		AMEX	
		Dept Store	
		Other	
Other Income		Medical Expenses	
Rental Property		Clothes	
Pension Income		Phone/Entertainment	
Social Security		Insurance	
Child Support		Childcare	
Alimony		Other Expenses	
Disability			
Other			
Total Monthly Income	\$	Total Monthly Expenses	\$
Total Number in Houshold			
Comments			
	Name of Bank		Amount
Checking			
Saving			
Home Equity			
Car Make and Model			
		Total Assets	\$
Please attach two copies of most recent bank statements			
Signature:		Date:	
By signing this document I certify that all of the information on this form is true and correct			
Application Received By:		Date:	