University of Louisville Physicians

Financial Assistance Application Cover Letter

University of Louisville Physicians offers financial assistance programs to meet the needs of our patients. The programs listed below apply only to University of Louisville Physicians charges.

In addition to the University of Louisville Physicians Financial Assistance Programs, you may also be eligible for public programs such as Medicaid. Applying for such programs may be required prior to applying for the University of Louisville Physicians Financial Assistance Program.

Financial Assistance Programs include:

Program	Available to	Description	How to Apply
Financial Assistance	Uninsured and/or Underinsured Patients	Offers free care or discounted care based on family size and income, according to the Federal Poverty Guidelines.	Complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements.	Contact the ULP Financial Counselor at (502) 588-3465.

To help us determine if you are qualified to receive financial assistance, please complete, sign, and return the enclosed application along with copies of the following **applicable** documents:

- ☐ Federal Income Tax Return
- ☐ Two (2) most recent paycheck stubs or other proof of income
- ☐ Driver's License or State-issued ID

If applicable, please submit the following:

- ☐ Food Stamp Award Letter
- ☐ Unemployment Compensation Benefit Award Letter
- ☐ Social Security Award Letter
- ☐ **Notarized** Room and Board Statement or a Written Letter of Support if no income

Return completed form and supporting documents to:
University of Louisville Physicians
Financial Counselor
300 East Market Street, Suite 400
Louisville, KY 40202

****NO PUBLIC ACCESS****

We will respond to you in writing within 30 days from the date we receive the completed application and required documentation. If you have any questions or need additional assistance, please contact our Financial Counselor at (502) 588-3465.

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Note: This application is for the University of Louisville Physicians charges only.

University of Louisville Physicians– Please print all information.

		Date of Application: _____
1. Patient Information*:		
Last Name	First Name	M.I
**If the patient is a minor or full-time student, please list parent(s)/guardian(s) as applicant and co-applicant.*		
1. Applicant (Patient/Parent) Information: Relationship to Patient (circle): Self Spouse Parent Other Marital Status (circle): Single Married Divorced Separated		
Last Name	First Name	M.I
Social Security Number	DOB	Phone
Address		
Current Employer		Employer Phone
Employer Address		Years Employed
2. Co-Applicant (Spouse/Parent) Information: Relationship to Patient (circle): Self Spouse Parent Other		
Last Name	First Name	M.I
Social Security Number	DOB	Phone
Address		
Current Employer		Employer Phone
Employer Address		Years Employed

Dependent Name	Relationship	Date of Birth	If 18 years old or older. Total gross monthly income (before taxes):

3. Income Information

List all contributing gross household income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends. If you do not have monthly income, you will need to provide information as to who is providing for you financially. Please complete the Room and Board Statement as documentation that you do not have monthly income.

Monthly Household Income Sources	Check those that apply and give amounts
☐ Employment Income	$
☐ Social Security	$
☐ Disability	$
☐ Unemployment	$
☐ Spousal/Child Support	$
☐ Rental Property Income	$
☐ Investment Income	$
☐ Other:	$
☐ Other:	$
Total Gross Monthly Income	$

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4. Assets		
Checking Account Balance $	Savings Account Balance $	Other $

Circle all that apply to any household member:

401K	Stocks	Bonds	Health Insurance Savings Account
Trusts	Property	Own a Business	Other:

Have you applied for Medicaid or any other state/local assistance? (circle one) Yes / No

If yes, please provide the following: Application Date: Status of Application:

Caseworker's Name: Caseworker's Phone:

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss.

5. Additional Information/Comments:

Applicant Signature	Date
Co-applicant Signature	Date

6. Signature: Completion of this form is not a guarantee of eligibility for Financial Assistance, or any other program. By signing I certify that all information is valid and complete. I will immediately notify the University of Louisville Physicians if my financial circumstances change.
   - I certify that the information I have provided is true and accurate to the best of my knowledge.
   - I will independently or with the assistance of financial personnel apply for ANY and ALL assistance which may be available through federal, state, and local government and private sources 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 to qualify for assistance.

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Financial Assistance Estimated Monthly Expense Report

1.PATIENT NAME	PLEASE PRINT ALL INFORMATION	
Last Name	First Name	Middle Name
2. INSTRUCTIONS:		
Please complete the following information in fts entirety and return to the address below.		
3.ESTIMATED MONTHLY LIVING EXPENSES:		
Monthly Expenses	Monthly Payment	List Other Monthly Payments
House /Mortgage/Rent Payment	s	
Property Taxes (if not included in Mortgage)	s	
Home Owners Insurance (if not included in Mortgage)	s	
Food	s	
Telephone (Home/cell)	s	
Child Support	s	
Spousal Support / Alimony	s	
Child care	s	
Credit card Total balance owed $	s	
Health Insurance Premiums	s	
Medical Balance	s	
Automobile Insurance	s	
Automobile Gasoline	s	
Liens/Wages Garnishes	s	
Prescriptions	s	
Utilities: Electric	s	
Utilities: Gas	s	
Utilities: Water	s	
TOTAL MONTHLY PAYMENTS		
4. ADDITIONAL INFORMATION FOR CONSIDERATION		
5. SIGNATURE		
Applicant Signature	**Date**	**Co-Applicant Signature**

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Room and Board Statement

Patient Name: (Print)

The person named above has advised us that you either contribute substantially to their financial support or you are their sole means of financial support. Please have notarized before submitting.

The type of support I / we provide is: (please complete all that apply)

_____**Room and Board, since (date)** _____

_____**Allowance of $** _____

_____**Every week**
_____**Every two (2) weeks**
_____**Every month**

_____**Other (please explain)**

I / We, (print)_____**have been the sole/substantial support for the person named above and, to the best of my / our knowledge, declare that this person has no other primary means of support. I/We will continue to provide room and board, but will not be responsible for medical expenses incurred.**

Signature 1	**Signature 2**
Relationship to Patient	**Relationship to Patient**
Address, Street	**City, State Zip**
Telephone	**Date**
Notarized Date	