Tri-Rivers Healthcare, PLLC

NOTICE TO PATIENTS:

This practice serves all patients regardless of inability to pay for primary care.
Discounts for essential services are offered based on family size and income.
For more information, ask at the front desk or visit our website.
Thank you.

AVISO PARA PACIENTES:

Esta práctica sirve a todos los pacientes, independientemente de la incapacidad de pago para la atencio'n primaria.
Descuentos para los servicios esenciales son ofrecidos dependiendo de tamaño de la familia y de los ingresos.
Usted puede solicitar un descuento en la recepción o visita nuestro sitio web.
Gracias.

11/2016

Tri-Rivers Healthcare, PLLC
141 Hospital Dr.
Salem, KY 42078
(270) 988-3298

Patient Name: _____ Account #: _____
Date of Service: _____

The Financial Assistance Program is a program designed to help pay clinic bills. Eligibility is based upon your income and assets prior and up to the date of service. It is the patient's responsibility to provide all necessary documentation in order to process your application. See below.

_____ Federal tax returns for the most recently filed year. (most recent two years if self-employed.)

_____ Pay stubs or a letter from your employer as proof of income for the past six (6) pay periods prior to and including your date of service from _____ to _____ inclusive. A form letter can be provided. If you are married, both patient and spouse information is required.

_____ Proof of disability or social security income listed.

_____ Proof of income from any and all sources: support payments, welfare, unemployment, pension, stock dividends, and child support payments. Any other income, which helps with daily living must be provided.

_____ Proof of assets: Checking and Savings account statements or a printout from the bank, which covers the date of service.

_____ Letter from the person supporting you, explaining the situation including their relationship to you, address, length and type of support they provide. A form letter can be provided.

_____ Most recent retirement statements.

_____ Most recent principle home property value assessment of home.

_____ Most recent home principle mortgage statement showing outstanding balance.

_____ Most recent vehicle registration renewal notice showing the value of vehicles.

_____ Two forms of ID for the patient, one form of ID for all other family members (i.e. drivers license, birth certificates, social security card).

Please provide copies of all requested documents. **Do not send originals through the mail.** If you do not have access to a copier you can bring all documentation to the office and a Patient Relations Representative will make copies for you.

If you have questions please call our office at (270) 988-7352.

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Attachment C

Tri-Rivers Healthcare, PLLC
111 Hospital Dr.
Salem, KY 42078
(270) 988-3298

Financial Assistance Application

Name: _____ Date of Birth: _____
Address: _____ _____ _____ _____
Street Address/PO Box City State Zip
Phone Number: _____ Social Security Number: _____

Family Members Living In Household:

Dependant Name	Date of Birth	Relationship	Social Security Number

***If more attach sheet**

INCOME PATIENT INCOME SPOUSE/OR OTHER DEPENDENT_____

Employer Name: _____ Employer Name: _____
Address: _____ Address: _____
City, State, Zip _____ City, State, Zip _____
Salary: (Gross Monthly) _____ Salary (Gross Monthly) _____

Other Income	Patient's Monthly Income	Spouse/Other Dependent's Monthly Income
Social Security/ Pensions/Annuities	$	$
Unemployment or Workmen's Comp Benefits	$	$
Interest/ Dividend Income	$	$
Child Support/Alimony	$	$
Veteran's Benefits	$	$
Rental Income	$	$
Other	$	$

Attachment C

ASSETS

Real Estate: Own _____ Rent ____		Bank: Name/Address	
Market Value:	$	Bank: Checking	$
Amount Owed:	$	Bank: Savings	$
Auto/Truck/Type:		IRA/Tax Sheltered Annuities:	$
		Life Insurance:	$
Market Value:	$	Money Market:	$
Motorcycles, Boats, Campers, Etc.:	$	Stocks, Bonds, CD's:	$
		Rental Property Owned:	$
Market Value:	$	Business Property Owned:	$
Retirement Funds	$	Other:	$

Household Expense

Rent or House Payment:	$	Medical Insurance	$
Electric, Propane, Oil:	$	Life Insurance	$
Water/Sewer:	$	Other Medical Bills	$
Trash:	$	Auto Insurance: (Annual) $	
Telephone:	$	Property Tax: (Annual) $	$
Mobile Telephone:	$	Other Loans:	$
Child Care:	$	Misc. (Specify)	$
Food and Supplies:	$		$
Auto Payment:	$		$
TV, Cable, Dish, etc.:	$		$
Credit Card:	$	**Total Household Expenses:**	$

I/We do hereby certify that the information provided above is accurate and a true representation of my/our financial information. I/We understand that this application must be completed and returned to the Financial Counselor within 30 days of discharge for self pay patients. I/We understand that the falsification of any information submitted with this application will result in denial of application.

I/We agree to provide the necessary verification of my/our income and authorize Tri-Rivers Healthcare, PLLC to make all inquiries that Tri-Rivers deems necessary to verify the accuracy of the statements made herein, including but not limited to procuring a credit report from the credit bureau and/or other financial institutions. Tri-Rivers reserves the right to deny any application upon their review.

Date: _____ Signed: _____

Date: _____ Signed: _____

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Attachment D

Tri-Rivers Healthcare, PLLC.
141 Hospital Dr.
Salem, KY 42078
(270)988-3298

Please answer the questions below. Questions which are answered Yes must have accompanying documentation.

1. Do you have/have you applied for Medicaid? When? _____ What is the status? _____	Yes	No
2. Is anyone in your household pregnant?	Yes	No
3. Were you working prior to your Date of Service?	Yes	No
4. Do you receive Welfare (cash benefits)?	Yes	No
5. Do you or your spouse receive unemployment?	Yes	No
6. Does anyone in your household receive Social Security or SSI?	Yes	No
7. Have you recently filed a Workers Compensation claim?	Yes	No
8. Are you or you spouse receiving a pension?	Yes	No
9. Is anyone in your household covered by health insurance or health savings account (HSA)?	Yes	No
10. Do you pay / receive child support?	Yes	No
11. Are you being supported by someone else?	Yes	No
12. Does anyone else in claim you on their income tax return?	Yes	No
13. Do you and or your spouse have a checking or savings account?	Yes	No
14. Do you have any other assets which may be used to help pay your hospital debts?	Yes	No

If yes explain: _____
_____
_____

Other Documentation which MUST be provided:
Two forms of identification for you. One form of identification for your spouse or minor children.

Patients Signature:_____ Spouses Signature:_____

Financial Counselor Signature:_____ Date:_____

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Attachment E

Tri-Rivers Healthcare, PLLC
141 Hospital Dr.
Salem, KY 42078
(270) 988-3298

Release Of Information

Date: _____

I _____ hereby authorize you to release Employment, Insurance,
(print name)
Income, Bank Account balances, ect., to Tri-Rivers Healthcare, PLLC. This information will help me to apply for financial assistance with my hospital bills.

I understand that Tri-Rivers Patient Relations Representatives are required to keep all information confidential and that further disclosure of information is prohibited without my express written consent.

I am aware that this authorization will expire 3 months from my dated signature.

_____ _____
Patient Signature Date

_____ _____
Financial Counselor Signature Date

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