Account #: _____ Status: _____
For Office Use Only

Financial Assistance
Instructions

1. Complete all information on the Financial Assistance Application.
2. Complete the Zero Income Form, additionally, only if there is no household income for 3 consecutive months.
3. The B.H.I. Financial Assistance Program is applicable to KY residents only.
4. The responsible party must sign and date the form for validity (page 2).
5. The following documentation is required with this application:

    1. A complete copy of the previous year's personal and business federal tax returns.
    2. Last three months statements of all checking, savings, and investments.
    3. Last three months of all earned household income.

        A: Proof of Social Security (award letter with monthly income stated).
        B: Proof of disability benefits/income.
        C: Proof of pension benefits.
        D: Unemployment benefits.
        E: Proof of KTap benefits/income.

    4. A valid photo ID.

6. An opt-out form is also available, if you wish to refuse Breckenridge Health's financial assistance program.
7. The Financial Counselor will determine discounting according to our Financial Assistance Policy and guide you through possible insurance coverage options. Income information is required to be updated annually.

8. Please mail completed application and all supporting documentation to:

Breckinridge Health Inc.
Attn: Financial Counselor
1011 Old Hwy 60
Hardinsburg, KY 40143

Please refer to the income guidelines within the application. If you are over the income guidelines, continue to complete the form. All applications will be scanned for assistance options. If you should have questions, contact the Financial Counselor at 270-580-2280 or the Business Office at 270-756-6579. Free copies can be obtained at the Business Office and all admitting areas located within Breckinridge Memorial Hospital. They are also at all off-campus clinics and at www.mybreckhealth.org.
Please call the Financial Counselor or Business Office to request a copy via mail, if necessary.
Business Office Hours of Operation Mon-Fri 7 A.M.-4 P.M. CST.

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Zero Income Form

Date: _____

Name: _____

We would like to try to assist you with your account(s) here at Breckinridge Health. If there is **no income**, as you have indicated on your application, please fill in this form and return to the Business Office. We will need your signature as well as a witness' signature to verify this information. Your witness must supply his/her phone number as well.

1. Applicant is living with or rent/utilities are paid by:
    - Relationship to applicant?

2. Applicant's necessities such as food and clothing are paid by:
    - Relationship to applicant?

3. Applicant has been without income since:
    - If less than 3 months, please send last check stub.

4. Applicant will be without income until:
    - Explain why applicant is not working:

5. If applicant is disabled, please list date applied for disability:
    - Status of application (approved, denied, pending)

*If applicant is off work due to illness or injury, he/she will need to submit a doctor's statement, in addition to this completed letter.

Applicant's Signature_____

Witness' Signature_____

Account #: _____ Status: _____
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Phone number of Witness _____

Opt-Out Form

I, _____ , choose to refuse benefits offered by the Breckinridge Health Inc. financial assistance program. I acknowledge that I am financially responsible for the balance due for this date of service. If I do not meet my financial obligations, I understand I am subject to collection efforts as Breckinridge Health Inc. deems necessary. I have been advised that this refusal applies to only this date of service, and that I will be offered assistance or an opt-out form for each additional service incurred.

Patient Name: _____

Patient or responsible party signature_____

Relationship to patient: _____

Date: _____