Pikeville Medical Center

Financial Assistance Application

911 Bypass Road, Pikeville, KY 41501

(606) 430-3303

PATIENT AND FAMILY INFORMATION

Patient Name _____ SSN _____ DOB _____

Patient Address _____ City_____State_____ Zip _____

Telephone _____

Spouse/Guarantor Name _____ SSN _____ DOB _____

Spouse/Guarantor Address _____ City_____ State_____ Zip_____

Telephone _____

Dependents

Name_____ Age_____ DOB_____

Name_____ Age_____ DOB_____

Name_____ Age_____ DOB_____

If over 19, copy of tax return or full time status is required

EMPLOYMENT INFORMATION

Patient Employer_____ Hourly Wage_____ Hours/Week _____

Spouse/Guarantor Employer_____ Hourly Wage_____ Hours/Week_____

Total Income $_____

TOTAL OTHER INCOME

Social Security $_____

Pensions $_____

Supplemental Security Income (SSI) $_____

Other (Interest, Rental, Alimony, etc) $_____

Worker's Compensation $_____

Unemployment Compensation $_____

Food Stamps (Not counted) $_____

Total Income $_____

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COUNTABLE ASSETS/RESOURCES

Bank Accounts – Name of Bank _____

Checking $_____ Savings $_____ CD $_____

Credit Union Accounts – Name of Credit Union _____

Checking $_____ Savings $_____ CD $_____

Investments $_____ Money Market Accounts $_____

Savings Bonds $_____ Other $_____

HOUSEHOLD EXPENSES

Rent/Mortgage	$_____	Electricity	$_____
Loan/Lease Payment (1 Vehicle)	$_____	Water	$_____
Insurance Premiums	$_____	Sewer	$_____
Telephone (1 Landline or Cell)	$_____	Natural Gas	$_____
Trash	$_____		

I hereby state that the above information is true and correct to the best of my knowledge. By signing this document, I agree to notify Pikeville Medical Center of any changes in my financial position.

Patient's Signature_____ Date_____

HOSPITAL USE ONLY

RECOMMENDATION

Approved_____ Denied_____

Hospital Assistance $_____ Patient Responsibility $_____ Expiration_____

Counselor_____ **Date** _____