Responsible Party Name: ________________________ Date of Birth: ____________ SSN: __________________
Address: _______________________________ Phone: ______________________
_______________________________ Marital Status: _________________
Spouse Name: ______________________ Spouse Date of Birth: ____________ Spouse SSN: _________________
Primary Insurance: _____________________ ID#: _____________________ Kentucky resident? (Y / N)
Secondary Insurance: ___________________ ID#: _____________________ Patient pregnant? (Y / N)

Household Member's Name	Relationship	SSN	Age

(Use back of page for additional Household Member's) Number of people in the household (including patient) ________

EMPLOYMENT:

Employer _____________________________________ Spouse Employer ____________________________________

GROSS INCOME:		**Monthly ($)**
Responsible party or patient's gross wages from paychecks/W2s		__________
Spouse's and any children's gross wages from paychecks/W2s		__________
Alimony		__________
Social Security		__________
SSI/Disability/K-Tap		__________
Unemployment		__________
Pension		__________
Food Stamps		__________

Other Income (e.g., Investment, Workers' Comp): Yes/No (Circle one) If yes, list: ________________________

TOTAL MONTHLY INCOME	$	__________
EXPENSES:		
Rent/Mortgage	$	__________
Food and Supplies		__________
Utilities		__________
Telephone		__________
Childcare		__________
Insurance Premiums (auto, health, dental, life, home, etc.)		__________
Prescribed Medications		__________

Other Expenses? Yes/No (circle one) If yes, list: ____

TOTAL MONTHLY EXPENSES:	$	___________
RESOURCES:		
Checking and Savings Accounts	$	___________
Stocks and Bonds Values		___________

Real Estate other than primary residence: Value ____________ Balance Owed __________
Other resources? Yes/No (circle one) If yes, list: ____
Have you applied for any Federal, State, or private financial assistance programs? (Y / N) If so what? (Medicaid, Food Stamps etc.)

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold information in applying for assistance, my application may be denied and Taylor Regional Hospital may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify TRH of any changes to the information provided in this form including address, telephone number and income.

____ _________________________
(Responsible Party Signature) **(Date)**

____ _________________________
(Witness /Hospital Employee Signature) **(Date)**