



Dear King's Daughters' Patient:

Enclosed is a Charity Care / Sliding Fee application, this application is being provided to you as a service of King's Daughters' Hospital and Health Services to try and assist you with your medical bill acquired through services rendered at our hospital and or with our physicians.

This application must be completed in its entirety and returned to King's Daughters' Hospital with all requested documentation. You must provided the following information prior to your application being processed, failure to do so will result in the delay of your application being processed.

**Recent pay stubs for you and your spouse**  
**Current Bank Statements for your checking and savings accounts**  
**Most recent years Federal Tax Return**

You may also be required to apply for state assistance before you may qualify for our Charity Care / Sliding Fee Program.

Once the application has been completed in full and returned to our facility, your application will be processed within 30 days. You will be notified by mail of your Charity Care / Sliding Fee status. Our decision will be based on all information provided within the application.

For additional information or questions about the Charity Care / Sliding Fee Program offered by the Hospital, or to make payment arrangements, please contact Customer Service at (812) 265-0161.

Thank You,  
King's Daughters' Hospital and Health Services  
Customer Service Department  
(812) 265-0161

**Services provided under  
The King's Daughters' Hospital and Health Services  
Charity Care & Sliding Fee Scale Program**

Services are only covered for urgent or medically necessary services. Physicians may be required to provide a written request for medically necessary and urgent services.

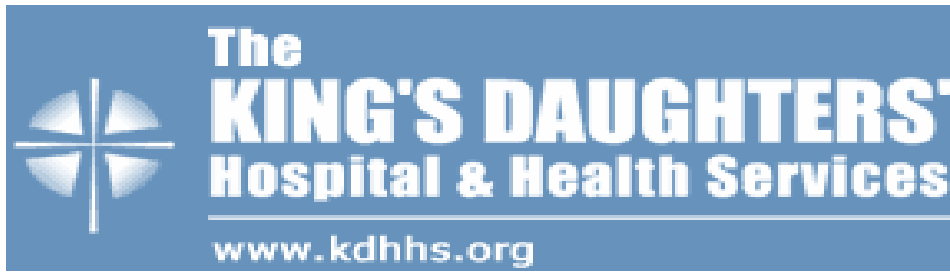
**Emergency Services  
Physician Office Visits and Procedures  
Ambulatory Surgical Unit  
Scheduled Surgical Procedures that are pre-approved  
Transitional Care Unit  
Oncology  
Magnetic Resonance Imaging  
Computed Tomography Scan  
Diagnostic Lab, Medical Imaging, or Cardio-Pulmonary Services  
Physical, Occupational, or Speech Rehabilitation Services  
Home Health, Hospice, Home Infusion**

**Services not provided under the Charity Care & Sliding Fee Scale  
Program**

**Non urgent services  
Non-employed KDH physicians  
KDH physicians (charges) that do not participate in the CC/SFS Program  
Contracted Services  
Screening Services  
Wellness Program  
Routine Services (e.g. Mammograms, Routine Female Exams, Well Child Check)  
Auto, Liability & Workmen Compensation related services  
Pre-employment/Employment Physicals (e.g. DOT)  
School Sports Physicals**

**IMPORTANT INFORMATION:** It is the patient's responsibility to work with the hospital, and make sure completed CC/SFS application is turned in with all paperwork requested. All surgical procedures must be pre-approved. CC/SFS does not cover elective services.

If the patient has opportunity to have insurance through an employer, Medicaid, or any other insurance, and choose not to apply for that assistance, CC/SFS will be denied. CC/SFS does not cover co-pays, or deductibles. If the patient has a co-pay or deductible, that balance is due from the patient.



P.O. Box 159 Madison, IN 47250
Telephone: 812-265-0161
Toll Free: 800-272-5341

Charity Care and Sliding Fee Scale Program
Financial Assistance Application

Patient Name: \_\_\_\_\_
First Middle Last

Home Phone # ( ) \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_

(Street Address verification REQUIRED – such as a House payment, Rent Lease, Utility bill)

Address: \_\_\_\_\_
Street Name City & State Zip

County in which patient lives: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Mailing address if different from above \_\_\_\_\_

Patients Employer Name: \_\_\_\_\_ Employer Phone # ( ) \_\_\_\_\_

Please mark appropriate box: \_\_\_\_\_ Male \_\_\_\_\_ Female Patient's Social Security #: \_\_\_\_\_

Guarantor's or Spouse Information

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_
First Middle Last

Please mark appropriate box: \_\_\_\_\_ Male \_\_\_\_\_ Female Social Security #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone # ( ) \_\_\_\_\_

Number of IRS tax dependents living in patients household: \_\_\_\_\_

Dependents Name	Dependents Relationship	Dependents Age	Male or Female

**Please circle your insurance coverage type:**

Private/Group      Medicaid      Medicare      Self Pay      Automobile/Liability      HCI/ClaimAid

**Income: This is NOT optional.**

**Without the listed information below your application will not be processed.**

- 1. Copy of current pay check stubs or a letter from the employer stating gross income and year to date earnings, for both you and your spouse.**
- 2. If you or your spouse are unemployed and have no income you must submit a letter explaining how you are covering your basic monthly living expenses such as rent, food utilities.**
- 3. Copy of last year’s tax return—If you did not file taxes last year, you must complete IRS Form 4506-T attached to this application.**
- 4. If you or your spouse are receiving income from another source, such as Social Security, Retirement, Alimony, Child Support, VA, Disability, etc... You must also provide proof of income for that source.**

**MONTHLY INCOME TOTALS**

<b>Patient’s or Parents Employment Income</b>	\$	<b>Spouse or Guarantors Employment Income</b>	\$
<b>Social Security Income</b>	\$	<b>Unemployment</b>	\$
<b>Childs Support</b>	\$	<b>Pensions</b>	\$
<b>Investment / Rental Income</b>	\$	<b>Stocks &amp; Bonds and CD Interest</b>	\$
<b>Disability Income</b>	\$	<b>Other Income</b>	\$

**Banking Information: This information is NOT optional.**

<b>Financial Institution Name</b>	<b>Account Type (Checking, Savings, Etc)</b>	<b>Account Number</b>	<b>Account Balance</b>

**I agree under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to cooperate with King’s Daughters’ Hospital, in providing the proper information needed to qualify the patient for King’s Daughters’ Financial Assistance program.**

**I understand that if I do not qualify for uncompensated services, I will be personally liable for these charges of services rendered by the hospital or physician practice or I may appeal the decision in writing with additional documentation.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

### Request for Transcript of Tax Return

(Rev. April 2006)

Department of the Treasury  
Internal Revenue Service

- ▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**
- ▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-1872

**Tip:** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506**, Request for Copy of Tax Return. There is a fee to get a copy of your return.

<b>1a</b> Name shown on tax return. If a joint return, enter the name shown first.	<b>1b</b> First social security number on tax return or employer identification number (see instructions)
<b>2a</b> If a joint return, enter spouse's name shown on tax return	<b>2b</b> Second social security number if joint tax return
<b>3</b> Current name, address (including apt., room, or suite no.), city, state, and ZIP code	
<b>4</b> Previous address shown on the last return filed if different from line 3	

**5** If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

**King's Daughters' Hospital --Attn: Cheryl Patton--PO Box 447--Madison, IN 47250**

**Caution:** If a third party requires you to complete Form 4506-T, **do not** sign Form 4506-T if lines 6 and 9 are blank.

**6 Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ \_\_\_\_\_

**a Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . .

**b Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days . . . . .

**c Record of Account**, which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . .

**7 Verification of Nonfiling**, which is proof from the IRS that you **did not** file a return for the year. Most requests will be processed within 10 business days . . . . .

**8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2003, filed in 2004, will not be available from the IRS until 2005. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . . .

**Caution:** If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

**9 Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Signature of taxpayer(s).** I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer.

<b>Sign Here</b>	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a (    )
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	