BEFORE YOU FILL OUT THIS APPLICATION FOR FINANCIAL ASSISTANCE ATTACHED - PLEASE NOTE: In order to qualify for UAB financial assistance the Alabama resident must have lived in Alabama for at least one year. Also any resident applying living in Jefferson County must apply at the Cooper Green Mercy Hospital before they will be accepted to UAB Callahan Eye Hospital.

UAB MEDICINE

CALLAHAN EYE HOSPITAL

PATIENT FINANCIAL ASSISTANCE APPLICATION ENCLOSED

In order for the Callahan Eye Hospital to evaluate your financial situation, we **must** receive all required information.

Pleas return the following information within thirty days so that we may process your application:

1. The completed charity Care Application attached to this letter.
2. Proof of your income, your spouse's income, and proof of income for anyone living with you of working age.
    - Most recently signed income tax form, complete with a copy of W-2(s), 1099,etc. If you did not file taxes verification of non-filing from the IRS is required. (IRS – 1-800-829-1040)
    - A copy of two (2) or more of your most recent pay stubs (or a letter from your employer that is notarized or on company letterhead verifying gross income.)
    - Proof of alimony, child support, unemployment, pension, etc.
    - Proof of Social Security income, if applicable.
3. **If you are unable to work due to an illness or disability, a letter from your physician confirming your inability to work is required. Form attached.**
4. If you receive no income and are being supported by relatives or friends, a **notarized** letter explaining these arrangements is required. The letter must be signed by any person(s) supporting you financially.
5. If you, your spouse, or anyone of working age living with you is unemployed, a **notarized** letter is also required stating length of unemployment, along with the name and relationship to you.
6. If you or anyone in your household receives food stamps, you must provide a copy of your most recent award letter or verification letter.
7. A copy of your denial letter from Medicaid indicating you are not eligible for the Medicaid program.
8. Ask your pharmacy to give you a printout of all prescription medications you have purchased in the last six (6) months.

*FALSIFYING INFORMATION ON THE FINANCIAL ASSISTANCE APPLICATION WILL RESULT IN US TAKING BACK ANY FINANCIAL ASSISTANCE PROVIDED TO YOU UP TO THAT POINT AND MAKE YOU FULLY RESPONSIBLE FOR YOUR MEDICAL BILLS. THIS ALSO APPLIES TO CHARITY/DISCOUNTED CARE RENEWALS.

*** Please also include a copy of the patient's Social Security card OR birth certificate and photo ID

UAB CALLAHAN EYE HOSPITAL
FINANCIAL COUNSELOR
OFFICE: 205-488-0737 OR TOLL FREE: 1-800-366-3937 FAX: 205-327-7817
1720 UNIVERSITY BLVD. BIRMINGHAM, ALABAMA 35233

UAB MEDICINE

CALLAHAN EYE HOSPITAL

FINANCIAL COUNSELOR OFFICE
1720 UNIVERSITY BLVD
BIRMINGHAM, AL. 35233
OFFICE 205-488.0737
FAX 205-327-7817

* Please Print

Date:_____

PATIENT INFORMATION MR# _____

Name _____ D/O/B _____
(Last) (First) (MI) (MM/DD/YY)

Present Address _____
Street/Apt Number City State Zip

Previous Address _____
Street/Apt Number City State Zip

Telephone Number ( ) _____ ( ) _____
Home Work

Social Security Number _____

RESPONSIBLE PARTY INFORMATION

Name _____ D/O/B _____
(Last) (First) (MI)

Present Address _____
Street/Apt Number City State Zip

Previous Address _____
Street/Apt Number City State Zip

Telephone Number ( ) _____ ( ) _____
Home Work

Social Security Number _____

Relationship to Patient _____

List all persons residing in household:

	NAME	AGE	Disabled?	Annual Income
Head of Household			Y/N	
Spouse			Y/N	
			Y/N	
Children or			Y/N	
Other Dependents			Y/N	
			Y/N	
			Y/N	

INCOME		EXPENSES	
DESCRIPTION	**MONTHLY INCOME**	**DESCRIPTION**	**MONTHLY EXPENSE**
List monthly household income from any of these sources:			
A. GROSS SALARY FOR PATIENT	$_____	A. RENT/HOUSE PAYMENT	$_____
NET SALARY FOR PATIENT	$_____	B. FOOD	$_____
EMPLOYER NAME _____		C. UTILITIES	$_____
B. GROSS SALARY FOR SPOUSE	$_____		(Elec./Water/Phone/Gas)
NET SALARY FOR SPOUSE	$_____	D. REPAIRS	$_____
EMPLOYER NAME _____			(Car or Home)
C. DIVIDEND AND INTEREST	$_____	E. INSTALLMENT LOANS - LIST:	
D. RENTAL INCOME	$_____	F. _____	$_____
E. PENSION INCOME	$_____	G. CAR PAYMENT	$_____
F. CHILD SUPPORT (INCOME)	$_____	H. OTHER CHARGE ACCOUNTS	$_____
G. ALIMONY (INCOME)	$_____	I. VISA/MASTER CARD	$_____
H. ADDITIONAL INCOME	$_____	J. CELL PHONE/PAGER	$_____
I. SOCIAL SECURITY BENEFITS	$_____	K. CABLE TV	$_____
J. V.A. BENEFITS	$_____	L. CHILD SUPPORT	$_____
K. WELFARE	$_____	M. ALIMONY	$_____
L. OTHERS - LIST	$_____	N. CHILD CARE	$_____
		O. MEDICAL TRANSPORTATION	$_____
		P. EDUCATION (Student only)	$_____
		Q. MONTHLY MEDICATION(S)	$_____
M. TOTAL INCOME PER MONTH	$_____	**R. TOTAL EXPENSES/MONTHLY**	$_____

ASSETS			
DESCRIPTION	**VALUE AMOUNT**	**DESCRIPTION**	
A. Checking Account	$_____	F. Car	$_____
Bank Name _____			
B. Savings Account	$_____	G. OTHERS - List:	
Bank Name _____		_____	$_____
C. IRA	$_____	_____	$_____
D. INSURANCE POLICY	$_____	_____	$_____
E. HOME	$_____	**H. TOTAL ASSETS**	$_____

I understand that the information I submit is subject to verification by the Callahan Eye Foundation Hospital and subject to review by state and/or federal enforcement agencies and others as required.

I am consenting to the UAHSF performing charity care administrative services for Callahan Eye Foundation Hospital and consent to UAHSF providing this information to Callahan Eye Foundation Hospital.

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient.

If your financial situation changes in the upcoming calendar year, these changes are to be reported to the Callahan Eye Foundation Hospital Financial Counselor immediately.

****My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, that I will provide the Callahan Eye Foundation Hospital with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be responsible for the total amount of bills accrued at the Callahan Eye Founation Hospital.**

****Financial assistance does <u>not</u> include medication.**

Signature of responsible party_____ Date signed _____

Patient Charity Care Application (Page 3 of 4) Name: _____

(Last) (First) (MI)

Please answer the following questions:

Are you currently on dialysis for kidney disease? Yes _____ No _____

Are you a kidney transplant patient? Yes _____ No _____

Insurance Information:

Do you have health insurance? If so, list below:

	Insurance Company	Policy #	Group #
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Is health insuance available to you through your employer? Yes _____ No _____

Have you declined health insurance coverage offered to you by your employer or through responsible person's employer? Yes _____ No _____

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to UAB Callahan Eye Hospital? Yes _____ No _____

If your admission is the result of an accident or injury, are you represented by an attorney? Yes ____ No _____ If yes, please complete the following information:

Attorney name: _____

Attorney address: _____

_____

Attorney telephone: _____

Are you eligible to apply for the Affordable Caer Act Health insurance coverage? Yes _____ No _____

If yes, what was the outcome? Provide insurance information or other outcome.

_____

If no, why are you not eligible to apply? _____

Comments: _____

_____

My signature below attests that the above information is valid and true.

Signature _____ Date _____

_____

Charity and discounted care does not cover the following services:

Organ transplants
Reconstructive surgery
Cosmetic surgery
Gastric Bypass
Breast implants
Breast reduction
Oral Surgery - excluding transplant and radiation treatment patients
Dentures
Treatment for infertility, including but not limited to artificial insemination
Medications
Durable medical equipment
Services not normally covered by health insurance

This is an example of services not covered under the charity or discounted care program. This list may not include all exclusions to the program. Should you have questions regarding your particular plan of care, please feel free to call our office.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements above.

Signature_____ Date_____

UAB Callahan Eye Hospital
Financial Counseling Services Office
1720 UNIVERSITY BLVD * Birmingham, Alabama 35233
Office: 205.488.0737 * Fax: 205.327.7817