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.
PATIENT FINANCIAL ASSISTANCE APPLICATION ENCLOSED

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

Please 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
1720 UNIVERSITY BLVD. BIRMINGHAM, ALABAMA 35233
* Please Print

**PATIENT INFORMATION**

Name _____________________________

(MR#) _____________________________

(D/C/B) _____________________________

(First) ____________________________

(MI) ___________________________

(At) __________________________

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 _____________________________

(First) ____________________________

(MI) ___________________________

(D/O/B) _____________________________

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?** Y/N

**Annual Income**

Head of Household

Spouse

Children or

Other Dependents

---
### INCOME

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

### ASSETS

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<tr>
<th>DESCRIPTION</th>
<th>VALUE AMOUNT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>A. Checking Account</td>
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<td>F. Car</td>
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<tr>
<td>Bank Name</td>
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<tr>
<td>B. Savings Account</td>
<td>$</td>
<td>G. OTHERS - List:</td>
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<tr>
<td>Bank Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. IRA</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>D. INSURANCE POLICY</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>E. HOME</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>H. TOTAL ASSETS</td>
</tr>
</tbody>
</table>

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 Foundation Hospital.**

**Financial assistance does not include medication.**

Signature of responsible party __________________________ Date signed __________________________
Patient Charity Care Application (Page 3 of 4) Name: ____________________________________________________________________________

(Log) (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:

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Policy #</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is health insurance 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 Care 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_________________________