UK HealthCare **UK Advanced Eye Care**

PATIENT DEMOGRAPHIC SHEET (Please complete ALL information)

PATIENT LEGAL NAME:	DATE OF BIRTH:	SEX:	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PRIMARY CONTACT PHONE #:	**HOME PHONE:**	**PREFERRED LANGUAGE:**	**RACE & ETHNICITY:**
PRIMARY CARE PHYSICIAN:	**PRIMARY CARE PROVIDER ADDRESS, CITY, STATE, ZIP:**	**PRIMARY CARE PROVIDER PHONE #:**	

EMERGENCY CONTACT INFORMATION

NAME:	RELATION TO PATIENT:	PRIMARY CONTACT PHONE NUMBER(S):

GUARANTOR INFORMATION

PARENT/GUARDIAN NAME:	RELATION TO PATIENT:	PRIMARY CONTACT PHONE NUMBER(S):
DATE OF BIRTH:	**SSN:**	**EMPLOYER:**

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:	SUBSCRIBER ID:	NAME AND RELATION TO PATIENT:

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:	SUBSCRIBER ID:	NAME AND RELATION TO PATIENT:

HealthCare

DOS

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

CONSENT TO TREATMENT: I consent to receiving medical care from the University of Kentucky. Medical care includes exams, testing, appropriate immunizations, medical treatment and treatment with controlled substances. I may be tested for HIV (the virus that causes AIDS), hepatitis and other diseases. My consent covers care from the agents, employees and medical staff of the University of Kentucky. No one has guaranteed me that the medical care will have certain results. I have the right (i) to make decisions about my health care, (ii) to refuse medical care, and (iii) to revoke this consent at any time except to the extent medical care has already been provided.
The patient or the authorized parent, guardian, responsible party or surrogate of the patient must give consent.

Images: I consent to let my health providers take and view images (such as photographs or video) for my care or identification. I understand and agree that some of these images may be retained while others are for real time monitoring only.

Teaching Institution: I understand that the University of Kentucky teaches and trains doctors, nurses and other health care providers (an academic medical center). Doctors in training (fellows, residents, interns, and housestaff), medical students and other medical trainees may be involved in my care with the appropriate supervision of my doctor.

Research: I understand that someone from the University of Kentucky may contact me in the future to ask me about my health or to take part in research.

FINANCIAL RESPONSIBILITY

Guarantee of Payment:I agree that I am responsible to the University of Kentucky and Kentucky Medical Services Foundation Inc. (KMSF) for charges resulting from services rendered at their prevailing rates. I agree that all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. Neither the University of Kentucky nor KMSF in enforcing any rights shall in any manner release me or any responsible party of liability. If the undersigned is more than one person, this obligation shall be joint and several. I agree that the University of Kentucky or KMSF is not a party to any disputed claim or peer-review, which affects payment of any claim filed on my behalf and that upon request for payment from the University of Kentucky or KMSF; I agree to pay any outstanding balance. If any legal action should be sought by the University of Kentucky or KMSF in connection with the collection of charges resulting from services rendered, I agree to be subject to (and hereby consent to) the jurisdiction and venue of any such action or proceeding in the courts within the County of Fayette, Commonwealth of Kentucky, and that I agree to waive any objection that I may have based on improper venue or inconvenient forum. For collection purposes, I authorize UK HealthCare and all of its entities and 3rd party agencies, to contact me on my cell phone or any other phone which I have provided as my contact information, or any number assigned to me that is available to the public, using methods which include pre-recorded/artificial voice messages or the use of automated dialer. Furthermore, I authorize UK HealthCare and all of its entities and 3rd party agencies, to communicate with me at the e-mail address provided or through text messaging.

Assignment of Benefits:I hereby assign all rights and privileges and authorize payment directly to the University of Kentucky and KMSF for any claim filed on my behalf or on behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the University of Kentucky and KMSF for charges not covered by this assignment or not paid on a timely basis by the insurance company.

What everyone needs to know about AIDS
Kentucky law requires that we inform you about AIDS.
HIV stands for "human immunodeficiency virus," which is a virus that attacks the body's immune system. HIV makes it harder for people with it to recover from other infections and illnesses. AIDS stands for "acquired immune deficiency syndrome," which is the health effects that happen if HIV is not treated. With treatment, a person living with HIV can be

healthy and live nearly as long as a person who does not have HIV. Treatment for HIV also greatly lowers the chance that someone with HIV will pass it to others.

HIV is **not** spread through activities such as hugging or shaking hands or sharing a drinking glass. HIV is **only** spread through blood, sexual fluids or breast milk.

This usually happens by: • Having sex without condoms • Sharing needles

AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

A mother living with HIV can pass HIV to her baby, but this is now very uncommon in the US as long as the mother knows that she has HIV and is being treated. It is also very rare that HIV is passed by blood transfusions or transplanted organs, because all donated blood and organs are now tested for HIV.

HIV is mostly spread by people who do not know they have HIV. This is why it is so important to get tested for HIV at least once in your lifetime, and at least every 6 months if you are having sex without condoms or sharing needles.

Treatment with Controlled Substances

Federal and state laws regulate controlled substances (drugs) that may be abused. Kentucky law requires that you consent to treatment with these drugs before you can receive them. Some illnesses and injuries can result in pain. Some drugs can make the pain more tolerable. Some other drugs can increase focus and reduce hyperactivity. Use of these drugs can cause nausea, sleepiness, drowsiness, vomiting, constipation, sleeplessness, loss of appetite, agitation, aggravation of depression, dry mouth, confusion, slower breathing, and loss of coordination making it unsafe to drive or operate machinery. These drugs can result in physical dependence, meaning that abrupt stopping may lead to withdrawal symptoms, psychological dependence, meaning that stopping may cause you to crave the drug, tolerance, meaning you need more drugs to get the same effect and addiction, meaning you may develop problems based on genetic or other factors. You must tell your doctor if you are pregnant or are considering pregnancy.

Living Wills

Please tell your provider if you have a Living Will, Advance Directive, Power of Attorney or any other document that allows someone to make healthcare decisions for you or documents your wishes regarding your care. **You are responsible for telling your care team if you have any of these kinds of documents.**

Certification: I certify that I have read and understand the consent and authorizations given above and that I am the patient or I am duly authorized by the patient to execute this document and accept its terms.

Rights and Responsibilities: I have been advised of my Rights and Responsibilities as a Patient.

NOTE: Interpretive services **must** be offered for preferred languages other than English.

Patient or Legal Representative

Date / Time

Relationship to Patient Interpreter Name or ID# In person or via Cyracom (circle one)

Notice of Privacy Practices

Effective April 14, 2003
Revised September 23, 2013

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by University of Kentucky health care facilities. The purpose of this Notice is to explain who, what, when, where and why your protected health information may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of protected health information as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.

- To request in writing a restriction on disclosures for payment or health care operations when paying out-ofpocket in full for health care item or service. We are required to agree to this restriction.

- To obtain a paper copy of this Notice and upon written request submitted to the UK health care facility maintaining the record, inspect and/or obtain a copy of your health record.

- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.

- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.

- To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.

- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the Medical Records unit of the facility where you originally filed your authorization.

- To be notified of a breach of your unsecured protected health information

- To receive a copy of your medical record in electronic format, if possible.

OUR RESPONSIBILITIES

Maintainthe privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your personal health information, including information obtained prior to the change.

Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS

Direct your questions, complaints and requests made pursuant to this Notice to: **Privacy Officer, 2333 Alumni Drive, Suite 200, Lexington, KY 40517, (859)323-1184 or (859)323-8002.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

Treatment: We may use and disclose your protected health information to anyone involved in the provision of health care to you, including for example, University physicians, nurse practitioners, nurses and other medical professionals, including our medical students, residents and volunteers. We may also disclose your protected health information to outside treating medical professionals and staff as deemed necessary for your health care.

Payment: We may use and disclose your protected health information to billing and collection agencies, insurance companies and health plans to collect payment for our services.

Heath Care Operations: We may use and disclose your protected health information for our own health care operations. For example, we may use your protected health information to assess your care in an effort to improve the quality and safety of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your protected health information to assist our compliance with applicable law.

Notice of Privacy Practices

Effective April 14, 2003
Revised September 23, 2013

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

Business Associates There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your protected health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.

Individuals Involved With Your Care: We may disclose your protected health information to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting the caregiver at the facility providing your care.

Legally Required Disclosures & Public Health: We may disclose your protected health information as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.

Heath Oversite Activities We may disclose your protected health information to a federal or state health oversight agency that is authorized to oversee our operations.

Workers Compensation: We may disclose your protected health information for workers compensation or similar programs.

Serious Threats to Health and Safety We may disclose your protected health information if necessary to prevent or reduce the risk of a serious or imminent threat to the health or safety of an individual or the general public.

Law Enforcement & Subpoenas: We may disclose your protected health information to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose your protected health information to others as required by court or administrative order, or in response to a valid summons or subpoena.

Inmates: We may disclose your protected health information to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.

Information Regarding Decedents: We may disclose your protected health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.

Research: We may also disclose your protected health information where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose your protected health information for research purposes with your authorization.

Treatment Alternatives We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund raising effort. You may opt out of fund raising communications by using the contact information listed on the fund raising material you receive

Directory information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting the Registration Office/Desk at the facility from which you received this Notice.

Appointment Reminders: We may use and disclose your PHI to provide a reminder to you about an appointment.

DISCLOSURES REQUIRING AUTHORIZATION

1. **Sale and Marketing of PHI.** We may not sell your PHI or use or disclosure your PHI for marketing purposes without your authorization.

2. **Psychotherapy Notes.** Most uses and disclosures of psychotherapy notes require an authorization.

3. **All other uses and Disclosures.** All other uses and disclosures of your protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all your protected health information that we maintain by posting the revised Notice at our facilities, making copies of the revised Notice upon request to the facility or the Privacy Officer, or posting the revised Notice on our website.

Notice of Privacy Practices

Effective April 14, 2003
This Notice was added to September 23, 2013 Version

Section 1557 of the Affordable Care Act (ACA) NOTICE OF NONDISCRIMINATION FOR UK HEALTHCARE PROGRAMS AND ACTIVITIES

The University of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The health programs and activities of the University of Kentucky:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified medical interpreters
    - Information written in other languages

If you need these services, contact any employee of a UK health program or activity.

If you believe the University of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Heather Roop, Section 1557 Coordinator, ADA Coordinator and Technical Compliance Officer
Institutional Equity and Equal Opportunity
University of Kentucky
13 Main Building
Lexington, KY 40506-0032

Telephone: (859) 257-8927
Fax: (859) 323-3739
E-mail: heather.roop@uky.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UK HealthCare Office of Patient Experience or Martha Alexander, Section 1557 Coordinator is available to help.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights' Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Telephone number: 1-800-368-1019
(TDD) number: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

UK HealthCare

Notice of Privacy Practices

Effective April 14, 2003
These Taglines Were Added to September 23, 2013 Version

YOUR RIGHT TO AN INTERPRETER

You have the right to an interpreter at no cost to you.

American Sign Language (ASL)
You have the right to an interpreter at no cost to you. Please point to this line. An interpreter will be called. Please wait.

ENGLISH — If you speak English, language assistance services, free of charge, are available to you.

SPANISH — Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.

CHINESE — 如果您讲汉语普通话，则可以免费向您提供语言协助服务。

GERMAN — Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

VIETNAMESE — Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

ARABIC — إذا كنت تتحدث العربية، فتوفر لك خدمات المساعدة اللغوية مجانًا.

SERBO-CROATIAN (SERBIC) — Ukoliko govorite srpski, na raspolaganju su vam besplatne usluge jezične pomoći.

JAPANESE — 日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

FRENCH — Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.

KOREAN — 모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

PENNSYLVANIA DUTCH — Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch.

NEPALI — यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंले बिना कुनै शुल्क भाषा सहायता सेवाहरू प्राप्त गर्न सक्नुहुन्छ।

CUSHITE (OROMO) — Yoo qooqa Oromo dubbatta tahe, tajaajilli gargaarsaa, baasi (kaffaltii malee) siif jira.

RUSSIAN — Если ваш язык — русский, то вам могут быть предоставлены бесплатные услуги переводчика.

TAGALOG — Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.

BANTU (KIRUNDI) — Niba uvuga Ikirundi, hari servisi itishurwa yo gusobanura indimi.

Services available in 200+ languages.

UK HealthCare

7-7702

HealthCare

DOS

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____ Time:_____ (Patient Label Here)

I understand that as part of my health care, University of Kentucky and its affiliates originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical treatment information to my bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The University of Kentucky and its affiliates' ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this notice.

_____

Signature of Patient or Legal Representative Date

_____

Witness Date

KENTUCKY EYE EXAMINATION FORM FOR SCHOOL ENTRY

KRS 156.160.8 (g) requires proof of a vision examination by an optometrist or ophthalmologist. This proof shall be submitted to the school no later than January 1 of the first year that a child is enrolled in a Kentucky public school, public preschool, or Head Start.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name:_____ Social Security Number:_____ Date of Birth:_____

Parent or Guardian Name:_____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230 CASE HISTORY

Date of Exam:_____

Chief Complaint:_____

Ocular History: Normal ☐ or Positive for:_____

Medical History: Normal ☐ or Positive for:_____ Drug Allergies: NKDA ☐ or Allergic to:_____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other:_____

Other Pertinent Information:_____

Refraction with cycloplegic? (please indicate one) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____

	Normal	Abnormal	Not able to Assess
External Exam (eye and adnexa)	☐	☐	☐
Internal Exam (media, lens, fundus, etc)	☐	☐	☐
Neurological Integrity (pupils)	☐	☐	☐
Binocular Function (stereopsis)	☐	☐	☐
Accommodation and convergence	☐	☐	☐
Color Vision	☐	☐	☐

Diagnosis: ☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other:_____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2_____

3_____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed:_____ Date:_____

Optometrist/Ophthalmologist

Address:_____ Telephone: ( )_____

Patient Financial Experience Department Updated: 08/2021

UK HealthCare The Power of Advanced Medicine

UK HealthCare Financial Assistance Application
Programa de Asistencia Financiera

Medical Record Number/No. de Cuenta: _____ Today's Date/Fecha: _____/_____/_____

Date(s) of hospital service provided or to be provided/ Fecha(s) que fue atendido o será atendido:_____/___/___ ---- /_____/

A	Patient Name/Nombre del paciente: (Last/Apellido), (First/Nombre), (MI)	Social Security Number/Número de seguro social	Date of Birth/Fecha de nacimiento
Phone/No. de teléfono	Work Ph./No. de teléfono del trabajo	☐ Single/Soltero ☐ Married/Casado ☐ Minor/Menor ☐ ced/Widowed/Div iudado	
Address/Dirección (Street/No. y calle) (City/Ciudad) (State/Estado) (Zip/Código postal)			How Long/Cuánto tiempo Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
B	Spouse(Esposo)/Parent(Padres)/Guardian(Tutor Legal) Name (Last/Apellido),(First/Nombre),(MI)	Social Security Number/ Número de seguro social	Relationship to Patient/ Relación con el paciente:
Phone/No. de teléfono	Address/Dirección:(Street/No. y calle),(City/Ciudad),(State/Estado),(Zip/Código postal)		How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
C	Co-Guarantor/Tutor Legal (Last/Apellido), (First/Nombre), (MI)	Social Security Number/ Número de seguro social	Relationship to Patient/ Relación con el paciente:
Phone/No. de teléfono	Address/Dirección:(Street/No. y calle),(City/Ciudad),(State/Estado),(Zip/Código postal)		How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:

D **Household Members – Each Person living in the Household/Integrantes del Hogar – Todas las personas que viven en la casa**

Name/Nombre	Employment Status/¿Trabaja esta persona?	Relationship/ Relación con el paciente	Age/Edad

E **Monthly Gross Family Income*/Salario Mensual del Hogar***

(a) Patient/Paciente: $	(b) Spouse(esposo)/ Co-Guarantor(Tudor Legal): $	(c) Retirement(Retiro)/ Pension(Pension): $	(d) Social Security (Seguro social/discapacitado): $
(e) Child Support (Manutención del hijo): $	(f) Unemployment/Desempleo: $	(g) AFDC / TANF / Welfare: $	(h) Alimony/Manutención del esposo: $
(i) Workers Comp Benefits/ Compensación de trabajadores: $	(j) Rental Property or Lease/ Propiedades de renta: $	(k) Guard (Guarda) / Reserves (Reserva) / Military (Militar): $	(l) Interest (Interés) / Dividends (Dividendos): $

(m) List Other Income / Assistance, Grants, Financial Aid and Scholarships please describe/Otros ingresos/ Asistencia, Favor de notar y describir::

$_____ $_____ $_____

TOTAL (a – m) $_____ **× 12 months (meses) = Annual Gross Income/ Salario total anual** **Total Income/ Salario total**: $_____

F **Countable Resources/Recursos Contables**

	Bank Name/Nombre de Banco	Balance/Value (Valor)
Checking/Cuenta corriente		$

Savings/Cuenta de ahorros		$
Certificate of Deposit/Certificado de Depósito		$
Money Market (Mercado de Valores), Mutual Funds (Fondo Mutuo)		$
Stocks (Acciones), Bonds (Inversiones), Other (Otros)		$

Total Health Bills Owed(Balance de todas las cuentas médicas): $ _____ **Total Resources (Recursos Totales): $** _____

Note Countable resources are reduced by unpaid medical expenses of the family unit to establish eligibility.
Nota Los recursos contables son reducidos por gastos médicos impagados de la familia para establecer elegibildad

University of Kentucky HealthCare●Patient Financial Experience Department●1000 South Limestone Room A101●Lexington, KY 40536 Phone: 855-211-4707●Fax: 859-257-8071

Patient Financial Experience Department Updated: 08/2021

2021 Federal Poverty Guidelines **Integrantes de la Familia** **Salario** **(Limite del Salario Anual)**

Household Size	Resource Limit		Household Size	Resource Limit	
1	$2,000.00	$12,880.00	2	$4,000.00	$17,420.00
3	$4,050.00	$21,960.00	4	$4,100.00	$26,500.00
5	$4,150.00	$31,040.00			

*Note: Income limits are effective as of April 1, 2021

All income of a family unit is to be counted. A family unit includes:

a. the individual
b. the individual's spouse who lives in the home
c. a parent or parents, of a minor child, who lives in the home
d. all minor children who live in the home

Related and non-related household member(s) who do not fall into one of the groups listed above are considered a separate family unit. *Countable resources are limited to cash, checking and savings, stocks, bonds, certificates of deposit, and money market accounts *Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility

*Nota: Los límites de salario son efectivos el 1 de abril de 2021. Todos los ingresos de la unidad familiar deben ser contados. Una unidad familiar incluye:

a) el individuo
b) el/la esposo/a del individuo que vive en el hogar
c) el padre o los padres de un niño menor de edad
d) que vive en el hogar todos los niños menores de edad que viven en el hogar Considerarán a los miembros relacionados y no relacionados de la casa que no califican en uno de los groupos mencionados arriba como una familia separada.. *Los recursos contables son limitados a una cuenta corriente y/o ahorros, acciones, inversions, certificados de depósito y cuentas de mercado de valores *Los recursos contables puede ser reducidos por gastos médicos impagados para determinar elegibilidad.

If you have insurance you can only qualify for financial assistance if your Annual Income Limit is 138% or less of the federal poverty level (Medicaid Spend Down and Medicaid copays are excluded). If your limit is over 138% of the poverty level we will be glad to work with you on a payment plan. We offer additional levels of financial assistance to our non-insured patient for those services covered under our financial assistance policy. If you have questions or concerns about your financial assistance applications please call (855) 211-4707

Si el paciente tiene seguro médico, solo puede calificar por asistencia financiera si su salario anual es el 138% o menos del nivel de pobreza federal (la tarjeta Medicaid Spend down y los co-pays de Medicaid son excluidos). Si su salario anual es más del 138% del nivel de pobreza federal estarémos disponibles para ayudarle con un plan de pagos. Nosotros ofrecemos niveles adicionales a los pacientes sin seguro médico para aquellos servicios cubiertos en nuestra póliza de asistencia financiera. Si usted tiene preguntas o quiere el estatus de su solicitud de asistencia, por favor llamar (855) 211-4707.

***Are you (the patient) a resident of Kentucky? "Resident" is defined as a person living in Kentucky and who is not receiving public assistance in another state.** **Yes** ☐ ☐ **No**

¿Usted, el paciente, es residente de Kentucky ? Un "Residente" se difine como una persona viviendo en Kentucky y quien no está recibiendo asistencia pública del otro estado. ☐ **Si** ☐ **No**

***Are you (the patient) (Please select all that applies)**
☐ ☐ ☐ ☐ ☐ ☐ **BLIND, DISABLED, OVER AGE 65, PREGNANT, a MINOR CHILD or have MINOR CHILDREN IN THE HOME?**
***If yes, you must contact the Department for Community Based Services in the county of your residence to apply for Medicaid.**

*** Por Favor ☒ todos que le corresponden. ¿Es el paciente ☐CIEGO, ☐ DISCAPACITADO, ☐ MAYOR DE 65 Años, ☐ EMBARAZADA, ☐UN MENOR DE EDAD o ☐TIENE HIJOS MENORES DE EDAD EN EL HOGAR? Si la respuesta es SI, usted deberá comunicarse con el Department for Community Based Services (DCBS) en el condado que vive para solicitar Medicaid**

If an individual claims to be permanently and totally disabled, refer the individual to both DCBS to apply for Medicaid and to the Social Security Administration to apply for SSDI/SSI.

Si un individuo confirma que es permanentemente y totalmente discapacitado, por favor referir al individuo a DCBS para aplicar para Medicaid y tambien la Oficina de Administracion del Seguro Social para aplicar para SSDI/SSI

***Was the date of service related to an auto accident?** ☐ **Yes** ☐ **No**

***La fecha del servicio fue debida a un accidente de auto?** ☐ **Si** ☐ **No**

Comments:
Número de
_____ **Limite de** **2021**
_____
_____

Comentarios:
_____
_____
_____

*I (we) hereby authorize the UK HealthCare (UKHC) to verify the information I have provided above. UKHC may verify employment and wages earned by contacting my employer or others. UKHC may obtain a financial credit report. I certify that the information provided on this application is correct and complete to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that a financial assistance application can be completed upon admission or at any time during the collection process up to when litigation begins or my account is transferred to a collection agency. UKHC reserves the right to make every reasonable attempt to collect from insurance companies or other third parties.	*Yo (Nosotros) autorizo a la Universidad de Kentucky HealthCare (UKHC) a verificar la información que he proveído en este formulario. UK podría comunicarse con mi empleador u otros para verificar mi salario. UKHC podría solicitar un reporte de mi crédito. Yo certifico que la información proveída en este formulario es correcta. Yo entiendo que si doy información falsa u oculto información para obtener asistencia financiera, podré ser acusado de fraude. Entiendo que el formulario para asistencia financiera podrá ser completado al ser admitido en el hospital o en cualquier momento durante el proceso de cobranza hasta que el litigio comience o mi cuenta sea transferida a una agencia de cobranza. La UKHC se reserve el derecho de realizar todo intento razonable de cobranza a las compañías de seguro médico o a terceras partes.

Signature (Firma): _____ Date (Fecha) _____UK HealthCare Employee: _____

University of Kentucky HealthCare●Patient Financial Experience Department●1000 South Limestone Room A101●Lexington, KY 40536 Phone: 855-211-4707●Fax: 859-257-8071