HMH Harrison Memorial Hospital
a regional medical center

1210 KY Highway 36 E
Cynthiana, KY 41031
Tel 859.234.2300
Fax 859.235.3699

Harrison Memorial Hospital is committed to providing financial assistance programs to persons who have healthcare needs and are uninsured, under insured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation.

These programs are not considered to be a substitute for personal responsibility. Patients are expected to cooperate with procedures for obtaining program assistance or other forms of financial assistance.

Patients whose family income is at or below 200% of the Federal Poverty Level may be eligible to receive free care. Liquid assets are also documented and taken into consideration to determine if a patient is eligible for financial assistance. The table below shall be used as guidance. (2026 Federal Poverty Guidelines)

Family Size	150%	200%	250%	300%-400%
1	$23,490	$31,320	$39,150	$46,980 - $62,640
2	$31,734	$42,312	$52,890	$63,468 - $84,624
3	$39,978	$53,304	$66,630	$79,956 - $106,608
4	$48,240	$64,320	$80,400	$96,480 - $128,640
5	$56,484	$75,130	$94,140	$112,968 - $150,624
6	$64,728	$86,304	$107,880	$129,456 - $172,608
ADJ	100%	75%	50%	25%

If you feel you may qualify for this program, please fill out the enclosed form in its entirety, supply the required documentation and return within 30 days from the date of this letter. If you have questions, please contact the HMH Business Office at 859-235-3780.

Sincerely,

Financial Counseling

Monday-Friday
8:00am-4:30pm
Phone: 859-235-3780
Fax: 859-235-3683

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FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

1. If uninsured, you must apply for Medicaid and receive a denial. The denial letter should be included with the application. Harrison Memorial Hospital's Business Office will assist any patient with the Medicaid application process.

2. Complete the Financial Assistance Application.

3. Include all monthly income, monthly expenses, and assets required on the form.

4. Provide the following required documentation:
    a. Last 3 months of checking and savings bank account statements
    b. Last 2 months of pay stubs
    c. Most recent tax return, showing dependents
    d. Benefit award letters for Social Security, Disability, Workers' Compensation and Veteran's Administrative benefits
    e. Proof of amount of child support
    f. Proof of amount for alimony
    g. Investment or Retirement Account statements

5. If you do not have monthly income, provide an explanation of how you meet living expenses.

6. Sign the Financial Assistance Application.

For any questions or assistance with the application, please contact the Financial Counselor.

- Phone (859) 235-3780
- Email financialcounseling@hmhosp.org
- Visit the HMH Business Office located in the Harrison Square Shopping Center at 1050 US Highway 27 S, Suite 6, Cynthiana, KY 41031

Mail completed application and required documentation to:

Harrison Memorial Hospital
Attn: Business Office
1050 US Highway 27 S, Suite 6
Cynthiana, KY 41031

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APPLICATION FOR FINANCIAL ASSISTANCE

RESPONSIBLE PARTY INFORMATION

Guarantor Name_____ SSN_____ Date of Birth_____

Spouse Name_____ SSN_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Daytime Phone Number_____ Evening Phone Number_____ Cell Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Insured Person_____

Secondary Insurance_____ ID#_____ Insured Person_____

EMPLOYMENT INFORMATION

Does your employer offer health insurance? ☐ Yes ☐ No

Employer_____ Position_____ Date of Employment_____

Spouse Employer_____ Position_____ Date of Employment_____

HOUSEHOLD INFORMATION

Household Member's Name	Relationship	SSN	Date of Birth

(use separate page for additional Household Members)

Total Number of People in the household (including patient)_____

HOUSEHOLD MONTHLY INCOME

Guarantor's Gross Wages from paychecks/W2s	$
Spouse's Gross Wages from paychecks/W2s	$
Bonuses/Tips	$
Unemployment Benefits	$
Public Assistance	$
Social Security	$
SSI/Disability/K-Tap	$
Retirement/Pension	$
Worker's Compensation	$
Alimony	$
Child Support	$
Rental Property Income	$
Income from all other sources	$
Total Monthly Income	**$**

HOUSEHOLD ASSETS

Cash on Hand	$
Checking Account Balance	$
Savings Account Balance	$
Stocks/Bonds/IRS/401(k)	$

Other assets? ☐ Yes ☐ No

If yes, list_____

_____

_____

Total Assets **$**

MONTHLY EXPENSES

House Payment or Rent	$
Utilities	$
Prescriptions	$
Childcare	$
Health Insurance	$
Medical Bills	
1	$
2	$
3	$
4	$
5	$
Total Monthly Expenses	**$**

If you indicate that you have no income, please explain how you meet your day-to-day expenses.

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 Harrison Memorial 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 HMH of any changes to the information provided in this form including address, telephone number, and income.

Guarantor Signature_____ Date_____

Spouse Signature_____ Date_____

For questions, please contact:
HMH Business Office
Phone: (859) 235-3780
Email: financialcounseling@hmhosp.org

Please return application to:
Harrison Memorial Hospital
Attention: Business Office
1050 US Highway 27 S, Suite 6
Cynthiana, KY 41031

OFFICE USE ONLY

Account Number	A/R Amount

Discount % Approved:
Date Submitted:
FC Signature:
Approval Signature:
Date Approved:

FINANCIAL ASSISTANCE INCOME VERIFICATION

Patient/Guarantor Name_____ Date of Birth_____

I, the above-named patient/guarantor, hereby certify there have been no changes to my financial status since my previous application for financial assistance from Harrison Memorial Hospital was completed and approved. By signing below, I verify the following assistance measures have not changed:

- Insurance Coverage
- Household Size
- Employment Information
- Gross Wages
- Social Security
- SSI/Disability
- Retirement/Pension
- Household Assets
    - Cash on Hand
    - Average Checking & Savings Account Balances

Please provide the following required documentation:

- Last 3 months of Checking and Savings bank account statements

Patient/Guarantor Signature_____ Date_____

OFFICE USE ONLY
FAP Original Approval Date_____ FAP Approved Discount %_____ Financial Counselor Signature_____

1-2024/R:7-25/ldr

PLAIN LANGUAGE SUMMARY

Harrison Memorial Hospital provides financial assistance to patients with no insurance or patients with insurance who have out-of-pocket responsibility that they are unable to pay. Anyone needing assistance will be required to complete the Financial Assistance application and provide all required documentation. Harrison Memorial Hospital may request additional information needed for application review by phone or mail.

Uninsured patients or insured patients with out-of-pocket balances will most likely qualify for **free** emergency or medically necessary care through the financial assistance policy if the following circumstances apply.

- The patient's annual household income is less than 200% of the Federal Poverty Level.
- The patient lacks a way to pay for charges using other assets.
- The patient has applied for Medicaid or other state and federal programs.
- The patient fully cooperates in the application process.
-

Uninsured patients or insured patients with out-of-pocket balances will most likely qualify for **discounted** emergency or medically necessary care under the financial assistance policy if the following circumstances apply.

- The patient's annual household income is 200% but not exceeding 400% of the Federal Poverty Level.
- The patient lacks a way to pay for charges using other assets.
- The patient has applied for Medicaid or other state and federal programs.
- The patient fully cooperates in the application process.
-

If a patient is approved for Financial Assistance, they will not be required to pay more than the amount Harrison Memorial Hospital generally bills patients that have insurance coverage for the same emergency or medically necessary care. Patients will also never be asked to make payments prior to or set up a payment plan to receive emergency services. For non-emergency services, a patient may be asked to make a payment on the day of service or establish a payment plan.

Services provided by contracted providers such as Radiologist, Anesthesiologist, Hospitalist, Pathologist and Emergency Room Providers will not be covered under the Financial Assistance policy.

Patients may obtain a free copy of this summary, the Financial Assistance Policy and the Financial Assistance Application from the Harrison Memorial website at www.harrisonmemhosp.org. Copies are also available through the HMH Business Office. All information can also be mailed directly to the patient by contacting the HMH Business Office at 859-235-3780.

The HMH Business Office is available to answer any questions or assist with the application process.

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PROVIDERS COVERED UNDER THE FINANCIAL ASSISTANCE POLICY

Any professional services rendered by a medical provider employed by Harrison Memorial Hospital (MD, APRN, or PA) will be covered under the Financial Assistance Policy. Services provided by contracted, non-employed providers are not covered under the Financial Assistance Policy. This includes but is not limited to services performed by radiologist, pathologist, anesthesiologist, hospitalist and emergency room physicians. Patients who qualify for financial assistance are highly encouraged to contact the HMH Business Office prior to service to confirm if the provider is employed by Harrison Memorial Hospital. The Business Office can be contacted by calling 859-235-3780.