Cabell Huntington Hospital
1340 Hal Greer Boulevard
Huntington, WV 25701

INDIVIDUAL NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES

To be eligible for uncompensated services, your family income must be at or below the following levels:

Family Size Unit	Federal Poverty Guidelines	80% Discount given on 120% FPG	60% Discount given on 140% FPG	40% Discount given on 350% FPG
1	$10,890	$13,068	$15,246	$38,115
2	$14,710	$17,652	$20,594	$51,485
3	$18,530	$22,236	$25,942	$64,855
4	$22,350	$26,820	$31,290	$78,225
5	$26,170	$31,404	$36,638	$91,595
6	$29,990	$35,988	$41,986	$104,965
7	$33,810	$40,572	$47,334	$118,335
8	$37,630	$45,156	$52,682	$131,705
For each additional person add	$3,820			

Revised: March 21, 2011

If you think you may be eligible for uncompensated services, you may complete the application on the back of this notice and return it to a Financial Counselor in the Registration Area. Office hours are Monday through Friday from 8 a.m. to 3 p.m.

The Financial Counselor will make a written determination of your eligibility for uncompensated care within two working days of your request.

So that determination may be made quickly, please be prepared to furnish documents ***verifying your income.***

You may be asked to make an application for assistance (Medicare, Medicaid, Insurance etc.) for payment of your hospital charges.

THE APPLICATION IS ON THE BACK OF THIS NOTICE!

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

Patient Name:		Account Number:	
Responsible Party:		Spouse:	
Employer:	How Long:	Spouse Employer:	How Long:

Family Income:	Month	Year	Monthly Expenses:	Month	Year
Responsible Party:			Housing (rent, mortgage)		
Spouse:			Vehicle:		
Social Security:			Utilities:		
Disability:			Food:		
Medicaid:			Gas:		
Retirement:			Prescriptions:		
Child Support:			Other (specify)		
Other (specify):			Other (specify)		
Total:			Total:		
Documentation required for proof of income					

Asset Review:		Liabilities:	
Home		Mortgage	
Vehicle		Car Loan	
Checking Account		Credit Cards	
Savings Account		Other Loan	
Total:		Other (specify)	
		Total:	

Patient Signature: ________________________ Date: ________________________

Cabell Huntington Use Only

Total Family Income: Last 12 Month: ___________ Last 3 months x4_________________ Family Size___________

Poverty Income Guidelines____

Date of Service______________________________________ Date of Request______________________________________

Eligibility Determination______________________________________

Your request for charity care at _____________has been approved because_________________________

□ Income not sufficient to cover expenses____

□ Limited assets____

□ Excess liabilities____

Your request for care at no charge was denied because_______________________________

Determination Date:______________________ Financial Counselor Signature:______________________

Business Office Director:__________________________