DSH-001 *(Rev. 03/09)*

APPLICATION FOR DISPROPORTIONATE SHARE HOSPITAL PROGRAM (DSH)

SECTION I. Individual Information

The following information is required to determine if an individual who requests or has already received hospital services is eligible for Disproportionate Share Hospital services or should be referred to the Department for Community Based Services (DCBS) to officially apply for Medicaid or KCHIP. Refer **all uninsured children aged 19 and under** to the DCBS office in the county of the individual's residence for a KCHIP eligibility determination.

1. Today's Date:_____

2. Patient Name:_____

3. Street Address:_____

4. City:_____ State:_____ Zip Code:_____

5. Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

6. Date of Birth: _____/___/_____ 7. Patient Sex:_____

8. Home Phone: _____ 9. Work Phone:_____

10. Date(s) hospital services provided: ____/___ /_____ - ____/____/____

11. Married/Single:_____ 12. Name of Spouse:_____

13. Is the patient pregnant? ☐ Yes ☐ No. If yes, refer the patient to DCBS for a Medicaid eligibility determination.

14. Is 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☐

If the answer to question 14 is **yes**, go to question 15. If the answer to question 14 is **no**, **advise the patient that he/she does not meet criteria for eligibility for DSH and complete Section V.**

15. List the name, social security no., relationship, and age of each person living in the household.

Household Members

Name	Social Security #	Relationship	Age

16. Does the individual have dependent children living in the home? Yes ☐ No ☐

(a) **If the answer to question 16 is YES**, refer the individual to DCBS for Medicaid;

(b) If the answer to question 16 is **NO**, refer the individual to DCBS for Medicaid **ONLY IF** the individual has **NOT** received a denial from Medicaid within 30 days; **or,**

(c) If the individual, who has no children less than 18 years of age, claims to be **disabled**, **refer** the individual to the **Social Security Administration** to apply for SSI.

17. **Income Information**:

Patient/Responsible Party Employer_____
Spouse Employer_____
Work Phone_____
Total Gross Monthly Income:_____
Other Income:
Unemployment_____
Soc. Sec._____ Workers Comp_____
SSI_____Other_____

Total Family Unit Gross Monthly Income: $_____

18. **Insurance Information**:

Health/Life Insurance:_____ Phone#_____

Policy #_____ Group#_____

Policy Holder_____ Relation to Patient_____

19. List the patient's countable resources below. Countable resources include: a checking account, savings account, stock, bond, mutual fund, certificate of deposit, money market account.

Countable Resources

	Bank Name	**Balance/Value**
Checking		
Savings		
Certificate Of deposit		
Money market		
Mutual fund		
Stocks		
Bonds		
Other		

***Total Health Bills Owed: $**_____
***Total Resource: $**_____
***Note**: COUNTABLE RESOURCES SHALL BE REDUCED BY UNPAID MEDICAL EXPENSES OF THE FAMILY UNIT TO ESTABLISH ELIGIBILITY.

Other Information:

Was date of service related to an auto accident?_____

Have you applied for and been denied Medicaid or KChip Benefits? Yes ____ No ____

SECTION II. Hospital Indigent Care Criteria

(1) An individual must meet all of the following conditions:
(a) The individual is a resident of Kentucky.
(b) The individual is **not eligible** for Medicaid.
(c) The individual is **not** covered by a 3rd party payor.
(d) The individual is **not** in the custody of a unit of government which is responsible for coverage of the acute care needs of the individual.
(e) The individual meets the following income and resource criteria:

Household Size	Resource Limit	100% of the Poverty Level (Monthly Income Limit)*	100% of the Poverty Level (Annual Income Limit)*
1	$2,000.00	$903.00	$10,830.00
2	$4,000.00	$1,214.00	$14,570.00
3	$4,050.00	$1,526.00	$18,310.00
4	$4,100.00	$1,837.00	$22,050.00
5	$4,150.00	$2,149.00	$25,790.00

Add an additional $3740.00 for each additional person

***Note- Income limits are effective April 1, 2009**

(2) **All income** of a family unit is to be counted and 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.
(3) Related and nonrelated household member(s) who do not fall into one of the groups listed above shall be considered a separate family unit.
(4) **Countable resources are limited to** cash, checking and savings accounts, stocks, bonds, certificates of deposit, and money market accounts.
(5) Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility.

SECTION III. Certifying Accuracy of Information

I hereby agree to furnish the Hospital all necessary information to allow them to determine my need to receive financial assistance for health care services received. I agree that the Hospital will be provided with or may obtain all documents necessary to verify my current income, employment status, and resources, and that failure to supply requested information within **ten** (10) working days is grounds for denial of my application for assistance. I also agree to notify the Hospital immediately of any change of address, telephone number, employment status, or income.

I agree to allow the Hospital representative to determine eligibility and pursue state and federal assistance with Medicaid, KCHIP and DSH.

I certify that the information provided on this application is correct 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 I have a right to request a fair hearing if I am dissatisfied with any action taken on my application. I understand that I must contact the hospital to make a hearing request.

_____ _____
Individual or Responsible Party's Signature Date

_____ _____
Hospital Employee Signature Date

Does the individual appear to qualify for Medicaid or KCHIP? Yes ☐ No ☐

If yes, then refer the individual to the DCBS office in the county of the individual's residence. The individual should take a copy of this form with him/her to the DCBS office.

SECTION IV. Refusal to Apply for Medicaid

The individual or his responsible party shall sign below if he refuses to apply for Medicaid.

I refuse to apply for Medicaid or KCHIP coverage. I understand that this refusal may result in me being billed for any services performed.

_____ _____
Individual or Responsible Party's Signature Date

SECTION V. Indigent Care Denial

The individual does not meet the criteria for indigent care. The individual may request a fair hearing regarding this determination within 30 days of this determination. The hospital shall conduct a fair hearing within 30 days of receiving the individual's hearing request.

_____ _____
Hospital Employee Signature Date

RETAIN A COPY OF THIS APPLICATION IN THE PATIENT'S RECORDS.
THIS DETERMINATION IS VALID FOR A PERIOD OF SIX MONTHS UNLESS THE INDIVIDUAL'S FINANCIAL SITUATION CHANGES.