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Schuyler County Hospital District Application For Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help us determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital. Approval is based only on family size and income alone.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 30 days after receipt of the form.

Patient Name: _____ Social Security Number: _____

Date(s) of Service: _____ Age: _____

Type of Services: _____ Inpatient _____ Emergency _____ Outpatient

Is Patient Covered By: _____ Insurance _____ Medicare _____ IDPA _____ Other

Person Financially Responsible for Bill (Guarantor)

Name: _____ Phone: _____

Address: _____
Street City State Zip

Employer: _____ Phone: _____

Address: _____
Street City State Zip

Name of Spouse: _____ Social Security Number: _____

Employer: _____ Phone: _____

Address: _____
Street City State Zip

Names of family members (That are claimed as a dependent):

Is patient or guarantor a college student: _____ Full Time _____ Part Time

Financial Information

List all sources and amount of family income. This must be complete and verified with W-2, paycheck stubs, tax returns or verification of wage from employer or from public assistance agencies.

Major Source:

Gross Income for prior 12 Months:

\$

Secondary Sources - Pensions, Social Security, Child Support, Public Assistance, Other:

\$

\$

\$

\$

Total gross family income for prior 12 months:

\$

Last 3 months total gross family income:

\$

Unemployed?

Yes

No

If yes, how long?

The following information will not be used for sliding fee schedule eligibility. Approval is based only on family size and income alone.

Future Income Expectations?

Assets

Checking & Savings Accounts

\$

Stocks, Bonds, Certificates

\$

Automobiles (including leisure vehicles, boats, campers, etc)

\$

Property - primary home, farmland, rental property, etc

\$

Other

\$

Total Assets

\$

<u>Expenses/Outstanding Bills</u>	<u>Balance Due</u>	<u>Monthly Payment</u>
House Payment	\$	\$
Rent	\$	\$
Utilities	\$	\$
Loans - home, vehicles, other	\$	\$
Medical Bills - dentist, doctor, pharmacy	\$	\$
Other	\$	\$
Total Expense/Bills	\$	\$

Other Circumstances you feel should be considered during the review of the application:

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, and financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Applicant

Date

Please note that if the approval of this application results in any balance being put on a new plan, new information/ documentation must be furnished annually. Failure to provide this information may result in modification and or termination of said payment plan.

Approved applications may be valid up to one year, provided the guarantor provides current paycheck/unemployment status, checking and/or savings account statements for the previous 3 months every quarter.

Before your application can be processed, you must provide the following documentation:

- Completed financial application
- Most recent federal/state income tax returns
- Paycheck/unemployment stubs for the past 3 months, or a written statement of earnings from employer (s)
- Forms approving or denying unemployment/workers compensation
- Statements of monthly benefits from social security income
- Denial received from Illinois Medicaid program
- Checking and/or savings account statements for the past 3 months

FOR HOSPITAL USE ONLY:

Approved

Denied

Reason

Signature of Hospital Reviewer

Date