APPLICATION FOR FINANCIAL ASSISTANCE

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:
Completing this application will help Illinois Valley Community Hospital (IVCH) determine if you can receive free or discounted services or other public programs that can help you pay for your healthcare. Please submit this completed application to IVCH.

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 IVCH determine whether you qualify for public programs.

Please complete this application and submit it to the hospital:

Mail: Illinois Valley Community Hospital
Patient Financial Services Department
925 West Street, Peru, IL 61354

Fax: Patient Financial Services Department/ Attn: Sara
815-780-3898

In-Person: Cashier's office, 1st floor of Hospital

Patient acknowledges the he or she has made good faith effort to provide all information requested in the application to assist IVCH to determine whether the patient is eligible for financial assistance.

If you need any help or more information, please call us at 815-780-4602 or 815-780-3418.

PATIENT INFORMATION

Patient Name: (Last)___________________ (First)_____________________ (Middle Initial)______

Patient Birth Date ___/___/_____ Social Security # (not required if uninsured):____________________

Phone Number (Cell): _______________________ Phone Number (Other): ______________________

Address: ____

City: _________________________________State: ______________ Zip Code: _______________

Was patient an Illinois resident at the time of service? Yes ☐ No ☐

Were services related to an alleged accident? Yes ☐ No ☐

Were services related to an alleged crime? Yes ☐ No ☐

Are medical services covered under a divorce or separation agreement that holds someone else responsible for payment of health care? Yes ☐ No ☐

Are services covered by insurance? Yes ☐ No ☐
If so, please list name of insurance company and policy number ____________________

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RESPONSIBLE PARTY/GUARANTOR/PARENT/PATIENT

If same as above, please check here ☐

Responsible Party Name: ____________________

Phone Number (Cell): ____________________ Phone Number (Other) ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Employer(s) Name(s): ____________________

Employer Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Employer Phone Number: ____________________

Spouse / Partner Name: ____________________

Phone Number (Cell): ____________________ Phone Number (Other) ____________________

Employer(s) Name(s): ____________________

Employer Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Employer Phone Number: ____________________

FAMILY/HOUSEHOLD INFORMATION

Number of persons in the Patient's family/Household: ____________________

Number of persons who are dependents of the patient: ____________________

Ages of dependents: ____________________

PRESUMPTIVE ELIGIBILITY CRITERIA

If you check any of the following boxes, please submit proof of eligibility. You do not need to fill out the Gross Monthly Family Income or Monthly Expenses sections below.	
☐ Homelessness	☐ Mental incapacitation; no one to act on patient's behalf
☐ Deceased with no known estate	☐ Eligible for Medicaid, but not on date of service or for non-covered service

GROSS MONTHLY FAMILY INCOME

(Including cases where spouse/partner is guarantor or parent is guarantor for a minor)

For verification purposes, you must provide copies of the following: two most recent paystubs or other income documents, or written verification from employer if paid in cash, most recent W-2 and 1099 forms, and most recent complete federal income tax return.			
Wages	$	Pension	$
Self-Employment Income	$	Worker's Compensation	$
Unemployment Compensation	$	Temporary Assistance for Needy Families (TANF)	$
Social Security	$	Retirement Savings Income	$
Social Security Disability	$	Child Support/Alimony/Spousal Support	$
Private Disability	$	Other Income (Please explain)	$

ADDITIONAL INFORMATION REGARDING FINANCES

For verification purposes, please include copies of most recent bank statement(s).			
Checking Account Balance	$	Stocks	$
Savings Account Balance	$	Mutual Funds	$
Health Savings/Flex Spending	$	Certificates of Deposit	$
Motor Vehicle: Make/Year ________________	Value: $	Motor Vehicle: Make/Year ________________	Value: $

MONTHLY EXPENSES

For verification purposes, please include copies of most recent bank statement(s).			
Housing: Rent or Mortgage	$	Transportation Cost	$
Utilities	$	Child Care	$
Food	$	Other Expenses (Please explain)	$
Outstanding Loans, including credit cards: Name: ________________ Name: ________________ Name: ________________	 $__________ $__________ $__________	Outstanding Medical Bills: Name: ________________ Name: ________________ Name: ________________	 $__________ $__________ $__________

CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge, and that I have made a good faith effort to provide all information requested in this application. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this IVCH bill. I understand that the information provided may be verified by IVCH, and I authorize IVCH to contact third parties to verify the accuracy of the information provided in this application. I agree to notify IVCH immediately if there are any changes to my financial situation that may affect financial assistance from IVCH. I also understand that if I knowingly provide false information in this application, I will be ineligible for financial assistance and any financial assistance granted to me may be reversed, and I will be responsible for payment of IVCH's bills.

____ ____________________________

Patient or Applicant Signature Date