Application for Determination of Eligibility for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Illinois Valley Community Hospital 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.

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 60 days discharge or receipt of outpatient care.

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

Patient Information

Patient Name: _____

Phone Cell: _____ Phone Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security #(not required if uninsured): _____

Email address: _____

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 medical care?	Yes ( )	No ( )
Are services covered by insurance?	Yes ( )	No ( )

Insurance: _____

Certificate / Policy Number: _____

Responsible Party / Guarantor / Parent / Patient

If same as above check here ( )

Responsible Party Name: _____

Phone Cell:_____ Phone Other:_____

Address:_____

City: _____ State: _____ Zip: _____

Spouse / Partner Name: _____

Phone: _____

Number of persons in the patient's family / household: _____

Number of person who are dependents of the patient: _____

Ages of patient's dependents: _____

Employment Information *(List all current employers-use back of form in necessary)*

Employer Name:_____ Phone: _____

Address: _____

City:_____ State:_____ Zip: _____

Spouse or Partner Employer

Employer Name:_____ Phone: _____

Address: _____

City:_____ State:_____ Zip: _____

Gross Monthly Family Income:

Wages: _____

Self-employment Income: _____

Unemployment Compensation: _____

Social Security: _____

Social Security Disability: _____

Veteran's Pension: _____

Private Disability: _____

Worker Compensation: _____

Temporary Assistance for Needy Families: _____

Retirement Income: _____

Child support, Alimony or Spousal Support: _____

Other Income: _____

Assets:

Checking Account Balance: $_____Bank Name: _____

Savings Balance: $_____Bank Name: _____

Stock Value: $_____Certificate of Deposit (Cos) value: $_____

Mutual Funds: $_____Health Savings Account Balance: $_____

Motor Vehicles:

Make:_____Year:_____Value $_____

Make:_____Year:_____Value $_____

Property:

Do you own income property? Yes ( ) No ( )

If yes, indicate monthly income: $_____

Address of income property: _____

Monthly Expenses *(Completion of this section is not required if the patient is: Homeless, deceased with no estate, mentally incapacitated with no Power of Attorney or Medicaid eligible but not for this date of service, or for non-covered Medicaid services):*

Housing expense $_____Utilities $ _____

Food $_____Transportation Cost $_____Child Care $_____

Outstanding Loans, including credit cards:

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Outstanding Medical Bills:

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Other Expenses not listed above:

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

Name:_____Amount Owed: $_____

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 that the information provide 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 that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the Hospital bill.

_____ _____

Patient or applicant signature Date

Please provide the following documents to support the above information. Failure to provide this information will result in your application being delayed and returned until the required information is provided:

1. Completed Financial Assistance Application
2. A copy of your current federal income tax records 1040 form. If you did not file federal taxes, please indicate the reason why. Send a copy of your bank statement, paycheck stub, unemployment benefits, or social security benefits for the current year.
    a. If filing with a Partner, civil union, please supply a copy of Illinois State income tax form.
3. If there is no employment, please have a family member or friend who supports you submit a signed statement verifying they are paying any or all of your living expenses.

Failure to provide all the required documents within 60 days from date of service may result in a delay in processing or denial of your request and/or your account resuming the normal collection process.

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