Encounter #:	Date:

FINANCIAL ASSISTANCE APPLICATION

Dear Patient/Guarantor:

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Memorial Health (Decatur Memorial Hospital, Lincoln Memorial Hospital, Jacksonville Memorial Hospital, Springfield Memorial Hospital and Taylorville Memorial Hospital) determine if you can receive free or discounted services or other public programs that can help pay for your health-care. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURTIY 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 240 days from the first post-discharge billing statement. Please return completed application and supporting documents by mail, electronic mail or hand deliver to the Patient Financial Services office at one of our hospitals.

Memorial Health | Attn: PFS | P.O. Box 19287 | Springfield, IL 62794–9287
financial.assistance@mhsil.com | Fax: 217–757–7595

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/GUARANTOR INFORMATION

Patient name Last	First	MI	Date of birth	Social Security number *(optional*)*

Race *(optional*)*	Ethnicity *(optional*)*	Sex *(optional*)*	Preferred language *(optional*)*

** Responses or nonresponses by the patient in fields marked "optional" will not impact the outcome of the application.*

Name of guarantor *(person responsible for paying the bill)*	Relationship to patient	Telephone—Home

Street address	City / State / ZIP	Telephone—Cell

Patient email, if preferred method of contact:

If the patient is divorced or separated, is the former spouse/partner financially responsible for the patient's medical care per the dissolution or separation agreement? ☐ Yes ☐ No

If yes, is the former spouse/partner's name and address correctly listed in the guarantor section above? ☐ Yes ☐ No

Were the services received related to any of the following? ☐ Accident ☐ Crime ☐ Workplace injury ☐ Other _____

FAMILY/HOUSEHOLD INFORMATION

Number of the persons in the patient's household:

Number of the patient's dependents *(as reported on tax return):*	Ages of dependents:

EMPLOYMENT INFORMATION *(list self-employed, disabled, retired or unemployed, if applicable)*

Employer of the patient

Employer of the patient's spouse/partner

Employer of the first parent or guardian *(if patient is a minor)*

Employer of the second parent or guardian *(if patient is a minor)*

INSURANCE INFORMATION *(list all insurance coverages related to services received, e.g., Medicare, Blue Cross, Veteran's, etc.)*

	Insurance Name	Policy Number	Group Number
Policy # 1			
Policy # 2			
Policy # 3			

Has the patient applied for Medicaid? ☐ Yes—awaiting approval ☐ Yes—not eligible ☐ No

PRESUMPTIVE ELIGIBILITY PROGRAMS *(please check for all that the patient qualifies)*

If you check any of the following boxes and you are uninsured, you do not need to fill out the Family Income section

☐ Women, Infants & Children Nutrition Program (WIC)	☐ Incarceration in a penal institution
☐ Temporary Assistance for Needy Families (TANF)	☐ Homelessness
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ Deceased patient with no estate
☐ Low Income Home Energy Assistance Program	☐ Religious order and vow of poverty
☐ Mental incapacitation; no one to act on patient's behalf	☐ Recent personal bankruptcy
☐ Receives grant assistance for medical services	☐ Illinois Free Lunch & Breakfast Program
☐ Medicaid eligibility, but not on date of service or for non-covered service	☐ IHDA Rental Housing Program

☐ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership *(for example, Central Counties Health Centers, SIU Center for Family Medicine—FQHC Program, Crossing Healthcare)*

FAMILY INCOME

	Patient *	Patient's spouse/ partner	First parent or guardian of minor*	Second parent or guardian of minor
Monthly gross wages or self-employment income				
Monthly unemployment compensation				
Monthly Social Security or Social Security disability				
Monthly veteran's pension				
Monthly veteran's disability				
Monthly private disability				
Monthly workers' compensation				
Monthly retirement income				
Monthly child support/alimony				
Other monthly income (please explain)				

** In the event that the patient (or parent or guardian) is divorced, list only the income for the patient (or parent or guardian) and include any monthly child support and alimony. In the event of a divorce, provide the required documentation below for only the patient (or parent or guardian).*

REQUIRED DOCUMENTATION *(information that must be sent with this application)*

Please check off that you have included the following:

☐ Copies of the previous year's federal tax return for both patient and spouse/partner or minor's parent(s) or guardian(s). Black out Social Security numbers.	☐ Copies of the monthly statements of Social Security benefits for both patient and spouse/partner or minor's parent(s)/guardian(s).
☐ Copies of the most recent W-2s and 1099s for both patient and spouse/partner or minor's parent(s)/guardian(s).	☐ Copies of proof of eligibility for one of the presumptive eligibility programs listed in the presumptive eligibility programs section for either the patient or minor's parent/guardian.
☐ Copies of the two most recent pay stubs for both patient and spouse/partner or minor's parent(s)/guardian(s).	☐ Copy of the form approving/denying assistance from the Illinois Department of Public Aid for the patient.
☐ Copies of the two most recent monthly statements for all checking, savings and investment accounts for both patient and spouse/partner or minor's parent(s)/guardian(s).	☐ Copy of a crime victim letter for the patient.
	☐ If no income, letter from the person paying the patient's living expense explaining the situation.

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 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 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.

Signature of patient or applicant Date

If you have questions or concerns about the application process, please call Memorial Health's financial counseling department at 217–788–4774 or 800–562–2829.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 877–305–5145 (TTY: 800–964–3013) or online at www.illinoisattorneygeneral.gov/consumers/healthcare.html.