

| | |
|--------------|-------|
| 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 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 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 Service Lobby office:

Decatur Memorial Hospital | Attn. PFS | 2300 N. Edward St. | Decatur, IL 62526
 DMHFinancialAssistance@mhsil.com | fax: 217-876-2281

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's name Last | First | MI | Date of birth | Social security number (optional*) | |
| Race (optional*) | Ethnicity (optional*) | | Sex (optional*) | Preferred Language (optional*) | |
| * Responses or non responses 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's 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If yes, is the former spouse/partner's name and address correctly listed in the guarantor section, above? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Were the services received related to any of the following? <input type="checkbox"/> Accident <input type="checkbox"/> Crime <input type="checkbox"/> Workplace injury <input type="checkbox"/> 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, eg. Medicare, Blue Cross, Veteran's, etc.) | | | |
|--|----------------|---------------|--------------|
| | Insurance Name | Policy Number | Group Number |
| Policy # 1 | | | |
| Policy # 2 | | | |
| Policy # 3 | | | |
| Has the patient applied for Medicaid? <input type="checkbox"/> Yes – Awaiting approval <input type="checkbox"/> Yes – Not eligible <input type="checkbox"/> 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

| | |
|--|--|
| <input type="checkbox"/> Women, Infants & Children Nutrition Program (WIC) | <input type="checkbox"/> Incarceration in a penal institution |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) | <input type="checkbox"/> Deceased patient with no estate |
| <input type="checkbox"/> Low Income Home Energy Assistance Program | <input type="checkbox"/> Religious order and vow of poverty |
| <input type="checkbox"/> Mental incapacitation; no one to act on patient's behalf | <input type="checkbox"/> Recent personal bankruptcy |
| <input type="checkbox"/> Receives grant assistance for medical services | <input type="checkbox"/> Illinois Free Lunch & Breakfast Program |
| <input type="checkbox"/> Medicaid eligibility, but not on date of service or for non-covered service | <input type="checkbox"/> IHDA Rental Housing Program |
| <input type="checkbox"/> 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 <i>(for example, Central Counties Health Centers, SIU Center for Family Medicine—FQHC Program, Crossing Healthcare)</i> | |

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 worker's 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:

| | |
|---|---|
| <input type="checkbox"/> 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. | <input type="checkbox"/> Copies of the monthly statements of social security benefits for both patient and spouse/partner or minor's parent(s)/guardian(s). |
| <input type="checkbox"/> Copies of the most recent W-2s and 1099s for both patient and spouse/partner or minor's parent(s)/guardian(s). | <input type="checkbox"/> 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. |
| <input type="checkbox"/> Copies of the two most recent pay stubs for both patient and spouse/partner or minor's parent(s)/guardian(s). | <input type="checkbox"/> Copy of the form approving/denying assistance from the Illinois Department of Public Aid for the patient. |
| <input type="checkbox"/> 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). | <input type="checkbox"/> Copy of a crime victim letter for the patient. |
| | <input type="checkbox"/> 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 Decatur Memorial Hospital's financial counseling department at 217-876-3785.

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 1-877-305-5145 (TTY: 1-800-964-3013) or online at www.illinoisattorneygeneral.gov/consumers/healthcare.html.