FINANCIAL ASSISTANCE APPLICATION

Dear Patient

IMPORTANT-YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help HMH 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 following the date of 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.

CHECKLIST:

Complete and sign the application

Most recently filed federal tax return document (or non-filing letter)

Most recent three months of detailed bank statements (checking and savings)

Most recent two months of gross income verification (all household members)

Denial Letter from Illinois Public Aid

Please note: HMHD will not be able to determine eligibility without proper documentation. Please ensure that you have assembled all required documents. Failure to send all required documents will result in a delay processing your application.

Please send in unaltered and unstapled copies of your documentation. HMHD is unable to return original documents being considered for financial assistance.

Patient deemed eligible for Presumptive Charity must still complete this application.

If you need help completing your applications or have any questions, please contact HMHD Patient Service with questions at (618) 643-2361.

By Mail
HMHD Hospital: Patient Business Services
Attn: Financial Assistance
PO Box 429
McLeansboro, IL 62859

By Fax
(618) 643-2502

To avoid processing delays of your application, please complete ALL fields that apply.

PATIENT INFORMATION				
Patient Name:	**DOB**	**Telephone Number**	**Patient Account#**	
Current Street Address	**Apt#**	**City/State/Zip**		**Live With Parents/Others**
Social Security Number:	**Marital Status**	**Family Size:** (Complete Household Section Below)	**Insured:**	**Have you applied for Medicaid:** Please include determination letter
Employed:	**Employer:**	**Years Employed?**	**If unemployed, name of last employer and dates worked:**	

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Patient Name:	**DOB**	**Telephone Number**	**Patient Account#**	
Current Street Address	**Apt#**	**City/State/Zip**		**Live With Parents/Others**
Social Security Number:	**Marital Status**	**Family Size:** (Complete Household Section Below)	**Insured:**	**Have you applied for Medicaid:** Please include determination letter
Employed:	**Employer:**	**Years Employed?**	**If unemployed, name of last employer and dates worked:**	

HOUSEHOLD INFORMATION

Please attach a separate sheet for additional household members, including all required documents.

Last Name	First Name	Relationship	DOB	**Employed? (provide Documentation)**	**Full Time Student (provide documentation)**	Monthly Income (provide documentation)	Dependent? (provide documentation)	Legal Status**
		SELF		**Employer:**	**Student Visa?**			
				Employer:	**Student Visa?**			
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HOUSEHOLD ASSETS**

Hamilton Memorial HOSPITAL DISTRICT

APPLICATION FOR FINANCIAL ASSISTANCE

Family Member Name	Checking Account(s) Bank Name	Acct Number and Balance	Savings Account(s) Bank Name	Acct Number and Balance	Other (IRA,CD, Etc.)	Balance

Family Member Name	Health Savings/Flex Spending Account (Value)	Vehicle (Year/Make/Model)	Vehicle Value	Real Estate (Primary Residence, Rental, etc.)	Real Estate Value	Other/Value

Attach a separate sheet for additional asset information, included all required documents.

HOUSEHOLD LIABILITIES**

Expense	Monthly	Balance Due
Housing		
Utilities		
Food		
Transportation		
Child Care		
Loans		
Medical Expenses		
Other Expenses (List)		
Other:		

Attach a separate sheet for additional liability information. ***Patients Receiving Care in Illinois Hospitals Only: If patient meets the presumptive eligibility criteria described in 77 ILAC 4500.40 or is otherwise presumptively eligible by virtue of family income, the patient is not required to complete this section of the application****

*****Patients receiving care from an HMH Rural Health Clinic are not required to complete this section of the application*****

PATIENT AGREEMENT

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.

______________________________ ______________________________

Patient Signature Date Responsible Party or Spouse Signature Date

Financial Assistance Summary

HMH is committed to providing financial assistance to people who are without insurance, underinsured, ineligible for a

Patients without enough insurance coverage also might be eligible for