MEMORIAL HOSPITAL

1900 STATE ST
CHESTER, IL 62233
PHONE: 618-826-4581 FAX: 618-826-2073

APPLICATION FOR UNCOMPENSATED CARE AND/OR UNINSURED DISCOUNT PROGRAM

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Memorial 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 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.

Form should be completed and returned to the Patient Accounts Department of Memorial Hospital, Chester IL.

UNCOMPENSATED/CHARITY CARE POLICY

Memorial Hospital will give uncompensated/charity care to those who require care that is medically necessary, but are unable to pay. This uncompensated/charity care will be available to all persons without discrimination based upon race, color, national origin, creed or other grounds unrelated to the individuals need for the medically necessary services of this facility. Uncompensated /charity care may be given in full or part based upon the applicant's financial situation and/or ability to pay. Criteria for uncompensated/charity care will be based upon the Federal Poverty Level Income Guidelines. Partial discounts will be assessed based upon up to 200% of the Federal Poverty Guidelines. Each applicant will be assessed based on need and financial situation. Persons requiring medically necessary care may request a determination of their eligibility for uncompensated/charity care prior to the service, after the service is provided, or even after collection action has begun. Memorial Hospital reserves the right to require proof of financial need. This requirement may be, but not limited to, proof of income, listing of assets, denials from public assistance program(s), tax returns or any other information that is necessary to substantiate the applicant's income and ability to pay. In addition, Memorial Hospital requires an application for the uncompensated /charity care be completed, signed and returned to the Patient Accounts Department.

UNINSURED PATIENT DISCOUNT

Memorial Hospital provides an Uninsured Patient Discount program for medically necessary services provided to patients with no insurance. Applicants must meet certain eligibility criteria. **This discount program is only available to residents of the State of Illinois and is based on household income of not more than 300% of the federal poverty income guidelines for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter (210 ILCS 89).** Memorial Hospital, Chester IL, reserves the right to verify proof of financial need which may include investigation services provided by an outside agency. Memorial Hospital reserves the right to automatically deny an application if information provided is found to be false or if requested information necessary to process application is not provided.

<u>You MUST supply the following information:</u>

- A completed and signed Charity Care/Uninsured Discount application. (Complete all 3 pages)
- A copy of recent (within last 6 months) acceptance or valid denial from your state's Public Aid Program
- Copies of either check stubs or proof of direct deposit for employment wages, Social Security, pension, unemployment, workers compensation or any other source(s) of income received in the past 90 days.
- A copy of most recent complete federal tax return. If self-employed, must include Schedule C.
- If accounts are auto accident, a copy of police report is required for verification of any and all possible insurance coverage

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Patient Information:

____ ____/____/____ __ __ __ - __ __ - __ __ __ __
Last name First Name Middle Initial Birthdate Social Security Number

Guarantor/Responsible Party

____ ____/____/____ __ __ __ - __ __ - __ __ __ __
Last name First Name Middle Initial Birthdate Social Security Number

______________________________________ __________________________ _______ _________
Street Address City State Zip Code

Mailing Address (if different than above) ____

Please list full name, age, and relationship of ALL persons residing with you, the guarantor. If more space needed please use the back of this page. (Examples of relationship: Husband, Wife, Child, Father, Mother, Friend, etc.)

Name:	Age	Relationship	Name:	Age	Relationship
_________________________	_____	_________	_________________________	_____	_________
_________________________	_____	_________	_________________________	_____	_________

Do you have any health insurance coverage? Y / N Name of Insurace: ________________________________

Reason you do not have health insurance coverage: ____

Do you have current Medicaid/HFS coverage: Y / N Have you applied for Medicaid/ HFS? Y / N *

***A copy of acceptance or valid denial from your state's Medical Public Aid Program is required**

If anyone in your household is currently employed or has been employed within the last 3 months, please complete the following (If more than 2 persons in household employed, please list information on a separate page):

Applicant Employer:____ or Self Employed _______

Employer Address: ______________________________City_____________________ State ________

Hours Worked Weekly:________ # How Often are you Paid?_________ Hourly Wage: $___________

______**Unemployed**: Last Employer:_________ _____________ How long unemployed:____________

Spouse/Other Occupant: Employee Name: ____

Employer: :____ or Self Employed _______

Employer Address: ______________________________City_____________________ State ________

Hours Worked Weekly:________ # How Often are you Paid?_________ Hourly Wage: $___________

______ **Unemployed:** Last Employer:_________ _____________ How long unemployed:____________

***Copies of 3 most recent paycheck stubs required for all persons employed**

INCOME: If anyone in your household has received money from any of the sources listed below <u>in the last 60 days</u>, please check the source and fill in the amount received <u>per month.</u>

___ Employment wages $___________

___ Self Employment or Farm Income $_________

___ Social Security/Disability Benefits $_________

___ Unemployment Benefits: $___________

___ TANF/SNAP/Food Stamps $__________

___ Private Disability $_____________

___ Child Support/Alimony $__________

___ Veterans Pension/Disability $_________

___ Pension or Retirement fund $_________

___ Workers Compensation: $_____________

___ Other Income: $__________

Do you pay child support? N Y Amount: $________

NOTE: Proof of the amounts listed above may be required. Examples are, but not limited to, copies of pay check stubs, proof of direct deposit, W2 forms, unemployment or disability statements, etc. <u>Please provide proof of any amounts listed above when turning in this application.</u>

If no income listed please explain how living expenses are being paid: ______________________________

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A copy of the <u>most recent year's</u> Federal Income tax return is also required. Please attach copy.

___ Copy of Federal Income Tax return for 201__ attached.

___ I did not file income taxes. Reason: ____

At any time during the 60 days prior to application or at present do you or anyone in your household have any of the following assets? Check ALL that apply. Fill in the current or estimated value of the asset. Proof of amounts may be required.

___ Checking Account $___________

___ Savings Account $____________

___ Certificate of Deposit (CD) $_________

___ Stocks $_______________

___ Mutual Fund $___________

___ Health Savings/Flexible Spending Account $________

Do you or anyone in your household own outright or are making payments on the following: Automobiles, Motorcycle(s), Boat(s), ATV(s), Personal Watercraft(s), etc. Please list specifics of all owned.

Year	Make (e.g. Honda)	Model (e.g. Accord)	Style (e.g LX)	Milage / or Hours (ATV, Boats,Etc)
_____	__________________	_______________	___________	_________________________________
_____	__________________	_______________	___________	_________________________________
_____	__________________	_______________	___________	_________________________________
_____	__________________	_______________	___________	_________________________________

Do you or anyone in your household own a Mobile Home or Camper Trailer? List Make, Model and Year:

___ Mobile Home Year:_____________ Make:________________ Model:_____________

___ Camper Year:_____________ Make:________________ Model:_____________

Housing Information:

Do you:

___ **Rent** Monthly Rent: $ ________ Do you receive Rent assistance? **No / Yes** Amount $ ___________

___ **Live With Family/Friends** (do not pay rent)

___ **Own** Home Value$___________________ Current Mortgage $________________

Do you own any property (other than current residence)?: Yes / No If yes please complete the following:

Property address: ______________________________________Value $__________Mortgage$___________

Briefly explain the reason you are applying from the Uncompensated Care and/or Uninsured Discount program offered by Memorial Hospital, Chester IL:_______________________________

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Certification Statement:

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.

Date: _____________

Applicant's Signature:____

Applicant Name (printed):____

Hospital Use Only:

___ Application received Date:______________ By: ____

___ Application completed using information dictated by applicant. Completed by _________________