SIH

☐ Memorial Hospital of Carbondale 405 W. Jackson Carbondale, IL 62902 (618) 549-0721 Ext 64572 Fax (618) 457-3004	☐ Herrin Hospital 201 S. 14th Street Herrin, IL 62948 (618) 942-2171 Ext 36458 Fax (618) 988-6153	☐ St. Joseph Memorial Hospital 2 South Hospital Drive Murphysboro, IL 62966 (618) 684-3156 Ext 55331 Fax (618) 529-0539	☐ SIH Medical Group 1239 East Main Street Carbondale, IL 62901 (618) 457-5200 Ext. 67575 Fax (618) 529-0562

Dear Patient/Guarantor:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help_____, 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.

Please understand in order to receive assistance with your hospital bill you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. must be fully exhausted before healthcare assistance will be considered.

Certain circumstances in which a patient may be eligible for presumptive eligibility may not require an application. Please contact a Financial Counselor at the number above to learn more.

Please return the application with the following information:

1. A complete Healthcare Assistance Program application signed and dated.
2. A copy of your last federal tax return filed. If self employed you must include Schedule C. Please include a copy of all W2's.
3. A copy of your most recent check or check stub for employment, unemployment, Social Security, pension, workmen's compensation (or work comp determination letter) or any other source(s) of income you have received for the past thirteen (13) weeks. We will accept one of the following three documents for proof of wages:
    a. An employee wage form filled out and signed by your employers for each wage earner in the household. (see application for this form).
    b. Copies of check stubs for the last 13 weeks.
    c. A print out of your wages from your employer for the last 13 weeks.
    d. The above wage information must be provided for all family/household members

4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Link, school lunches, Child Care Resource or Referral Program.

5. You may be asked to apply for assistance from other appropriate sources if it is determined you could qualify for such aid.

If you want to submit an appeal of our decision or request re-consideration it must be in writing. Please include the reason or provide additional information that may be beneficial for our review.

Please mail the completed application to the address listed above for the facility where you incurred charges. Only one application is required if you have accounts at any or all of the three hospitals listed above. If you need assistance in completing the application please contact the Financial Counselor at the appropriate facility. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

Completion of this application does not relieve you of your financial obligation to Southern Illinois Healthcare; Southern Illinois Healthcare reserves the right to deny any application upon review.

Sincerely,

Financial Counselor

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Healthcare Assistance Application

Name: _____ Date of Birth: _____

Address: _____ _____ _____ _____
Street Address/PO Box City State Zip Code

Phone Number: _____ Social Security Number _____ (not required)

Family/household information:

1. Number of persons in the patient's family/household: _____
2. Number of persons who are dependents of the patient: _____
3. Ages of patient's dependents: _____ _____ _____ _____

_____

Employment and Income Information

1. Enter patient's, patient's spouse or partner's employer information.
2. If patient is a minor, enter the patient's parent's or guardian's employer information.

Patient	Spouse	Partner	Other
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____

Other Income

Other Income		Patient's Monthly Income		Spouse/Partner/Other Dependent's Monthly Income
Wages		$		$
Self -Employment		$		$
Unemployment Compensation		$		$
Social Security		$		$
Social Security Disability		$		$
Veteran's Pension/Disability		$		$
Workers' Compensation		$		$
Temporary Assistance for Needy Families		$		$
Retirement Income		$		$
Child Support, Alimony or Other Spousal Support		$		$
Other Income		$		$

Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

Assets

Real Estate: Own _____ Rent _____		Bank: Checking	$
Market Value:	$	Savings	$
Amount Owed:	$		$
	$	Mutual Funds:	$
Auto/Truck/Type:		Stocks, CD's:	$
Market Value:	$	Rental Property Owned:	$
Motorcycles, Boats, Campers, Other Vehicles:		Other:	$
Market Value:	$		$
	$		$
	$		$

Monthly Expenses

Rent or House Payments:	$	Other:	$
Utilities:	$		$
	$		$
	$		$
	$		$
Child Care:	$		$
Food and Supplies:	$		$
Auto Payments:	$		$
Transportation:	$		$
Property Tax (Annual):	$		$
	$		$
	$		$
		Total Monthly Expenses:	

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.

Y ☐ N ☐ Was the patient an Illinois resident when care was rendered by the hospital?

Y ☐ N ☐ Was the patient involved in an alleged accident?

Y ☐ N ☐ Was the patient a victim of an alleged crime?

Y ☐ N ☐ Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?

Y ☐ N ☐ Does the applicant (s) have any insurance benefits?

Date: _____ Signed: _____
Patient/Applicant

Date: _____ Signed: _____
Patient/Applicant

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

_____
_____
_____

2. If your tax return is not included, please explain why.

_____
_____
_____

3. If you have no income how do you support yourself?

_____
_____
_____

4. If you are receiving financial support from anyone, include a written statement as to who and how they are helping you.

_____
_____
_____

5. Other:

_____
_____
_____
_____
_____
_____
_____

EMPLOYEE WAGE FORM

(To Be Completed and Signed By Employer)

Employee Name: _____

Employee Social Security Number: _____

Employer Name: _____Tele: _____Ext. _____

Address: _____
City State Zip Code

WAGES FOR THE LAST 13 WEEKS

WEEK	PAY PERIOD ENDING	GROSS WAGES
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____(yes/no), If no, when was the last day worked? _____
2. If the employee is not currently working, will the employee be returning to work? _____ (yes/no) Expected return date _____
3. When did employment begin: _____ End: _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____
Signed: _____
Signature of Employer's or
Employer's Representative