Healthcare Assistance

Harrisburg Medical Center	100 Dr Warren Tuttle Dr Harrisburg, IL 62946	P: (618) 253-0251 F: (618) 351-6540
Herrin Hospital	201 S. 14th Street Herrin, IL 62948	P:(618) 942-2171 Ext 36458 F: (618) 351-6540
Memorial Hospital of Carbondale	405 W Jackson Carbondale, IL 62902	P: (618) 549-0721 Ext 64572 F: (618) 351-6540
St Joseph Memorial Hospital	2 South Hospital Drive Murphysboro, IL 62966	P: (618) 684-3156 Ext 55331 F: (618) 351-6540
SIH Medical Group	1239 East Main Street Carbondale, IL 62901	P: (618) 457-5200 Ext 67575 or Ext 67722 F: (618) 351-6540

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

You may apply for free or discounted care within 240 days of discharge or receipt of outpatient services. By applying, you acknowledge that you have made a good-faith effort to provide all information needed to determine eligibility.

To receive assistance, all available payment sources such as insurance, Medicaid, Workers' Compensation, or liability coverage must be used first. Healthcare assistance is considered only after all other payors are exhausted. You may be asked to apply to other programs if it appears you could qualify.

Some patients may qualify for presumptive eligibility without submitting an application. Please contact a Financial Counselor to learn more.

How to Apply (choose one):

- **Chart:** mychart.sih.net
- **In person or by mail:** Send to the facility (addresses above)
- **Fax to:** (618) 351-6540

One application covers accounts the SIH locations listed above. If you need help completing an application, contact a SIH Financial Counselor, Monday through Friday 8:00 am–4:30 pm at the contact information listed above.

Submitting an application does not relieve you of your financial obligation unless you are approved. SIH reserves the right to deny applications upon review.

Appeals & Complaints

To appeal a decision or request reconsideration, submit a written letter with the reason and any additional documents to the facility (addresses above)

Complaints about the uninsured discount or financial assistance process may be reported to the **Illinois Attorney General – Health Care Bureau**: illinoisattorneygeneral.gov/consumer-protection **or 1-877-305-5145.**

SIH

Healthcare Assistance Application

Patient Information				
Name		Date of Birth	Social Security (not required)	
Address		City	State	Zip
Phone Number	Employment Status __ Employed __Self-Employed __Retired __Disabled __ Unemployed – last date worked:_____			
Number of People in Household	Number of Dependents of the Patient	Age of Patient Dependents		
Employer Name		Hire Date	Phone Number	
Employer Address		City	State	Zip
Name of Health Insurance plan, including COBRA				

Spouse, Partner, or Parent (if patient is a minor)				
Name		Date of Birth	Social Security (not required)	
Address		City	State	Zip
Phone Number	Employment Status __ Employed __Self-Employed __Retired __Disabled __ Unemployed – last date worked:_____			
Employer Name		Hire Date	Phone Number	
Employer Address		City	State	Zip
Name of Health Insurance plan, including COBRA				

Questionnaire		
Was the patient an Illinois resident or temporary resident when care was provided?	Yes	No
Was the patient involved in an alleged accident?	Yes	No
Was the patient a victim of an alleged crime?	Yes	No
Does the applicant(s) have any active or open Law/Legal suits for accounts that assistance is being requested?	Yes	No
Does applicant(s) have health insurance benefits OR Medishare/Ministry funded plan?	Yes	No

SIH

Healthcare Assistance Application

Monthly Income

- **Copy of the tax return (prior year), include all Schedules (A,B,C,D,E,F,1, etc)**
- **Copy of the two (2) most recent pay stubs with year-to-date (YTD) earnings OR completed Employer Wage Verification form(s)**
- **If applicable, copy of the most recent benefit letter for programs listed below**
- **If reporting $0 income, Letter of Support is required**

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

*Assets

Real Estate - __Own __Rent *Market Value: $* *Amount Owed: $*	Auto/Truck/Type – *Market Value: $* *Other Vehicles: $*
Checking Account	$
Savings	$
Mutual Funds	$
Stocks, Certificates of Deposit	$
Rental Property Owned	$
Other	$

***Assets are not required** for **National Health Service Corps (NHSC) locations** at:
SIH Primary Care Harrisburg, Eldorado Primary Care, HMC Marion Clinic, Logan Primary Care – West Frankfort, Benton Community Healthcare, Logan Primary Care – Herrin, Center for Medical Arts, Anna Primary Care, Medical Arts Clinic – Murphysboro, West Frankfort Family Medicine.

Monthly Expenses

Rent/Mortgage	$	Phone	$
Food	$	Internet	$
Utilities	$	Credit Cards	$
Vehicle Payment	$	Medical/Prescription	$
Transportation/Gas	$	Loans	$
Insurance	$	Other	$
Total Monthly Expenses	$		

SIH

Healthcare Assistance Application

Additional Information
If your monthly expenses exceed your monthly income, please explain how your expenses are met.
If your tax return is not included, please explain why.
Additional Information/Comments:

Additional Demographic Information (Optional)
Illinois law requires the inclusion of this section on this application. Responses or non-responses will not have any impact on the outcome of this application.
Sex (circle one) Male Female Male transitioning to Female Female transitioning to Male
Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino, or Spanish Origin
Race (circle one) American Indiana or Alaska Native Asian Black or African American Chinese Native Hawaiian or Other Pacific Islander Other Race White
Preferred Language (circle one) English Spanish Other-

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/Applicant Signature (required): _____ **Date:** _____

Patient/Co-Applicant Signature: _____ **Date:** _____

Updated: 11/1/2026

System Office
1239 E Main St
Carbondale IL 62901

618.457.5200
Fax 618.351.6540

LETTER OF SUPPORT (if applicable)

Complete this form if you receive financial support from another person (ex. you have no income). If you do not receive financial support from another party, this form is not applicable and is not required.

Date:_____ Applicant/Patient Name:_____
Accounts:_____

To Whom It May Concern:
I am currently providing the following support to the applicant named above

____Applicant receives $_____each month from me.
____I **do not** provide any monetary assistance to the applicant. I only assist the applicant with Rent, utilities, food etc.
____I claim the applicant on my Federal and State Income tax return.
____I **do not** claim the applicant on my Federal and State Income tax return.

To the best of my knowledge, this person **does not** receive assistance from any other source.
The arrangement began on _____and will continue until _____, unless the patient obtains employment or makes other living arrangements.

_____ _____
Signature of Party Providing Financial Support Date

_____ _____
Relationship to applicant Telephone Number