Memorial Hospital of Carbondale	Herrin Hospital	St. Joseph Memorial Hospital	SIH Medical Group
405 W. Jackson	201 S. 14th Street	2 South Hospital Drive	1239 E. Main Street
Carbondale, IL 62902	Herrin, IL 62948	Murphysboro, IL 62966	Carbondale, IL 62901
(618) 549-0721	(618) 942-2171	(618) 684-3156	(618) 457-5200
Ext 64572	Ext 36458	Ext 55331	Ext. 67575
Fax (618) 457-3004	Fax (618) 988-6153	Fax (618) 529-0539	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. You can submit this application to any SIH Medical Group facility or office.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR 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 determine whether you qualify for any public programs.

Please complete this form and submit it in person, by mail, by electronic mail, or by fax to apply for discounted care within 60 business days following the date the application was given.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist in determining whether the patient is eligible for financial assistance.

Please understand in order to receive assistance with your 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.

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 and a copy of all W2's. If self employed you must include Schedule C.
3. A copy of your most recent check stub for employment, unemployment, Social Security, pension, workmen's compensation (or determination letter) or any other source(s) of income received for the past 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.
   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/house hold 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. If you do not have a current denial letter from the Department of Human Services, please complete the attached Determination for Medicaid Eligibility form. You may be asked to apply for assistance from other appropriate sources if determined you could qualify for such aid. Staff is available to help you with Medicaid eligibility forms.

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 SIH Medical Group facility or office. If you need assistance in completing the application please contact the Financial Counselor at the address or phone number listed above. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

For your convenience, you can email your application and required documentation to the SIH Medical Group Patient Financial Services at: sihmedicalgroup.hap@sih.net.

Completion of this application does not relieve you of your financial obligation to SIH Medical Group; SIH Medical Group reserves the right to deny any application upon review.

This application is only valid for SIH Medical Group, however, upon request, it can be forwarded to any Southern Illinois Healthcare hospital listed above for a separate approval consideration.

Sincerely,

Healthcare Assistance Program Coordinator

SIH MEDICAL GROUP

Memorial Hospital of Carbondale
405 W. Jackson
Carbondale, IL 62902
(618) 549-0721
Ext 64572
Fax (618) 457-3004

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SIH Medical Group
1239 E. Main Street
Carbondale, IL 62901
(618) 457-5200
Ext. 67575
Fax (618) 529-0562

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 bill.

I understand that the information provided may be verified by SIH Medical Group, and I authorize them 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 bill.

Y	N	
☐	☐	Was the patient an Illinois resident when care was rendered?
☐	☐	Was the patient involved in an alleged accident?
☐	☐	Was the patient a victim of an alleged crime?
☐	☐	Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?
☐	☐	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

Determination for Medicaid Eligibility

Healthcare Assistance Application

Patient Name: ____

Please answer the following four questions to determine if you must apply for Medicaid.

**** If the answer to question # 1 is “No”, you must apply for Medicaid.

Are you a U.S. citizen? ____ Yes ____No

**** If the answer to any of questions 2, 3 or 4 is “Yes”, you must apply for Medicaid.

2. Are you under 65 **and** been determined disabled by a physician? ____ Yes ____No

3. Do you have dependents under the age of 18 living at home? ____ Yes ____ No

4. Are you pregnant? ____ Yes ____ No

Staff is available to help you with Medicaid eligibility. Please contact the Financial Counselor at the appropriate facility.

I certify that the information provided above is true and accurate.

______________________________ ________________
Signed Date