FINANCIAL AID APPLICATION

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

STEP 1: Short Form
If any of these situations apply to you check all that apply; SKIP TO THE LAST PAGE & SIGN ON THE LINE. You will be asked to provide proof of your situation:

- ☐ Homelessness (letter from person who knows you)
- ☐ Recent person bankruptcy (copy of document)
- ☐ Deceased with no estate
- ☐ Incarceration in a penal institution
- ☐ Mental incapacitation with no one to act on their behalf
- ☐ Affiliation with a religious order and vow of poverty
- ☐ Medicaid eligibility but not on date of service or for non covered service
- ☐ Enrollment in other Illinois or county assistance programs for low-income individuals
  - ☐ Patients who receive grant assistance for medical services
  - ☐ Women, Infants and Children's (WIC) Programs
  - ☐ Supplemental Nutrition Assistance Program (SNAP)

STEP 2: Short Form
If any of these situations apply STOP, you may qualify for other resources that will pay your claim. Contact the Business Office.

- ☐ This claim was due to an accident
- ☐ This claim was due to an alleged crime
- ☐ I have been deemed unable to work by a physician

If none of the above situations applied to you please complete items the remaining parts of the application. If you have any questions contact StacyAllen (618) 548-3194 ext 8212. We will need a copy of your current proof of all household income and your income tax return submitted with your application.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

PATIENT'S INFORMATION:

Patients Name:		DOB: / /	
Address:			
City:		State:	Zipcode:
Phone #:	( )	Email:	
Social Security #			

GUARANTOR'S INFORMATION (if different than patient's):

Guarantor's Name:			
Address:			
City:		State:	Zipcode:
Phone #:	( )	Email:	
Social Security #			
Total Family Size_____List each member of household below:			

Name:	Relationship to Patient:	Date of Birth:

INCOME:

Patient's (or Guarantor's)Employer		
Address :		Telephone #: ( )
Spouse's Employer		
Address:		Telephone #: ( )
Other Employment		
Address :		Telephone #: ( )

Type of Income	Patient (or Guarantor) Monthly/Annual		Spouse Monthly/Annual		Combined Annual Amount (12 Months)
Wages					
Self Employment					
Unemployment					
Social Security					
Social Security Disability					
Veterans Pensions					
Veterans Disability					
Private Disability					
Workman's Compensation					
TANF					
Retirement Income					
Child Support/Alimony					
Pensions					
Other Income (specify)					
Total Annual Income					

CASH ASSETS	Amount
Checking	
Savings	
Stocks/Bonds/IRA's	
Certificates of Deposit	
Mutual funds	
Real Estate property	
Health savings/Flexible Spending Account	
Other	
TOTAL FINANCIAL RESOURCES	

EXPENSES	Monthly Amount	Annual Amount
Home Mortgage or Rent		
Home Insurance		
Property Taxes		
Utilities		
Food		
Auto Insurance		
Child Care/Alimony		
Loans		
Other (specify)		
TOTAL ANNUAL 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 the application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for the financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill

____________________________________ __________________________________

Signature Date

HOSPITAL CLAIMS INFORMATION (for hospital use only)

☐ Amounts are balances after Insurance has paid

Account Number	Amount	Date of Service
Total Amount due		