SALEM Township HOSPITAL

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. Patients applying for financial assistance MUST apply for IL Medicaid and include a letter of acceptance or denial with their financial application before it will be processed.

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. 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
- ☐ Medicaid eligibility but not on date of service or for non covered service

**** Please include the following items with your financial assistance application:**

IL Medicaid letter of approval or denial

A copy of your total household income for the past 13 weeks, if married this includes spouse's income as well.

If retired, a copy of your annual award letter from Social Security Administration

Copy of most recent tax return

Please note that applications will NOT be processed without receiving this information.

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 Business **Services (618) 548-3194 ext 8145.** 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)
Other Income (specify)					
Total Annual Income					

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