SALEM Township HOSPITAL

1201 Ricker Drive
Salem, IL 62881
618-548-3194

Financial Assistance Application

Dear Valued Patient,

Salem Township Hospital offers a financial assistance program on a sliding scale, based on your total household income & family size, calculated by the Federal guidelines, in the event you **DID NOT** qualify for Medicaid. **All information is kept confidential**.

You may be eligible to receive discounted care up to 100% of your bill. Please complete the attached application in its entirety and provide ALL requested documentation, as applicable, indicated below:

1. Medicaid Denial Letter
2. Three months proof of income for all household members. (For example, 6 consecutive check stubs from employer if paid bi-weekly. In the event you do not have consecutive check stubs, please provide a print out from Human Resources from your employer on company letterhead indicating your last 12 weeks' pay.)
3. Social Security Disability Award Letter, Social Security Award Letter or SSI Letter if applicable.
4. Proof of pension, annuity, trust fund, unemployment, rental property income &/or worker's compensation payments (if applicable for all household members.)
5. Most recent tax return. (In the event you have not filed W-2's & all documents you will be using for filing for all household members along with the previous year's completed taxes.)
6. 2 months of checking & savings account statements. (Note: deposits should match income coming into the home, in the event you have additional deposits, please provide explanation of deposit in writing.)
7. Complete, sign, & date the application.
8. Return the application within 60 days of date of services to Salem Township Hospital, in person or via mail.

We are here to help! The Business Office at Salem Township Hospital is available to make copies of the needed documents for application processing. In the event you have any further questions in completing the application or needed documentation please contact us at (618) 548-3194 EXT 8169 between the hours of 8:00 am – 4:30pm. During the work week.

Our commitment is to provide excellence in health care and promote wellness for our community through compassionate care, personalized service and teamwork.
This institution is an equal opportunity provider and employer

Salem Township Hospital
Financial Assistance Application

PATIENT'S INFORMATION

PATIENT NAME:		DOB: / /
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE #	EMAIL:	
SOCIAL SECURITY #		

GUARANTOR'S INFORMATION (if different than patient)

PATIENT NAME:		DOB: / /
ADDRESS:		
CITY:	STATE:	ZIP CODE:
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	**Phone:**
Spouse's Employer:	
Address:	**Phone:**

Type of Income	**Biweekly/Monthly:**	**Annual**
Patient:		
Spouse:		
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 the application. I understand that is 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: ______________________