FINANCIAL ASSISTANCE APPLICATION

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Community Memorial Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

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.

To apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care, please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax**. In addition to this form a copy of the latest filed tax return, copies of last 3 paystubs, and last 2 months of bank statements will be required**. The patient will also be required to **apply for Medicaid**. Additional documentation may be requested as determined by Community Memorial Hospital.

Patient Information

Patient Name: _____ Social Security No. _____
Date of Birth._____ Phone Number _____
Address: _____ Account No. _____

Was the patient a resident of Illinois at the time of the services?	Yes / No
Were the services rendered due to an alleged accident?	Yes / No
Were the services rendered due to an alleged crime?	Yes / No
Is the patient homeless?	Yes / No
Is the patient now deceased with no estate?	Yes / No
Does the patient have a mental incapacitation with no one to act on patient's behalf?	Yes / No
Is the patient now eligible for Medicaid (if so please provide documentation)?	Yes / No

Guarantor Information (if different from above)

Guarantor Name: _____ Social Security No. _____
Address:_____ Phone Number _____

Family / Household Information

Please list all "family" members. Generally this should be all the people listed on the same tax return as the patient.

Name	Age	Date of Birth	Relation to Patient	Monthly Income	Source of Income / Employer
			Patient		

Is there any additional information regarding your financial status that you would like to add to this application?

_____

_____

Certification

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.

_____ _____ _____

Signature Date Relationship