Memorial Hospital and affiliates, PO Box 160, Carthage, IL 62321, (217)357-6591

Application for Determination of Eligibility for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Memorial 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 Patient Account Department.

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.

Applicant			
	First	**Middle**	**Last**
Address			
	Street/PO Box	**City**	**State/Zip Code**

Employer	**Home Phone**	**Social Security Number**

Family members or residents of current Household	**Name**	**Date of Birth**	**Relationship**	**Name**	**Date of Birth**	**Relationship**
			Self			

1. Are you or is the patient eligible for Medicaid or have they ever applied for Medicaid? **YES** or **NO**
   (If yes, please attach response from Public Assistance.)
2. Has the patient applied for insurance coverage through the Affordable Care Act process? **YES** or **NO**
   If yes, what was the outcome of the above process: ______________________________________
3. Was the patient involved in an accident? **YES** or **NO**
4. Is the patient a victim of crime and receiving treatment for this crime today? **YES** or **NO**
5. Does the patient receive any type of State or Federal Assistance such as food stamps, free lunches, WIC program, energy assistance, etc.? **YES** or **NO** If yes which one: ________________________.
   (Please provide us with documentation from that authority verifying your assistance in that program.)

Please review and sign on back page

I acknowledge that I have made a good faith effort to provide all information requested in the application to assist the hospital in determining whether I am eligible for financial assistance. 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, 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 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.

______________________________ ______________________________

Date Signature of Responsible Party

______________________________ ______________________________

Date Received Employee

FOR FACILITY USE ONLY

1. Does the patient meet Propensity to Pay? YES or NO N/A
   a. Poverty Level: ________
   b. Monthly Income: ________
   c. Predictor Score: _______
2. Are the services acute or chronic? ____________________________________
3. Are the services elective or medically necessary? ____
4. Are the services meeting the requirements for coverage under the American Cancer Society Guidelines (Pap smear, Screening exams, etc.)? **YES** or **NO** N/A

ANNUAL	FAMILY MEMBER #1	FAMILY MEMBER #2	FAMILY MEMBER #3	FAMILY MEMBER #4
GROSS WAGES	__________	__________	__________	__________
OTHER INCOME	__________	__________	__________	__________
TOTAL MEMBER INCOME	__________	__________	__________	__________

TOTAL FAMILY INCOME: ______________________________

PREPARED BY: ____________________________________ DATE: ______________________________