

**Passavant Area Hospital
Financial Assistance Policy**

As a tax exempt not-for-profit charitable organization, Passavant Area Hospital is committed to serving all persons in our community regardless of ability to pay. Anyone who identifies themselves as financially unable to pay all or part of their medical care will be eligible to apply for financial assistance. Individuals meeting the hospital's financial assistance guidelines will be granted free care or substantially reduced fees consistent with the individual's financial resources.

The hospital utilizes the Federal Poverty Level (FPL) guidelines as published annually in the Federal Register. Patients with a household income below 200% of the FPL, and without other substantial financial resources, and not eligible for Medicaid or other coverage, will be granted free care. Patients with a household income below 350% of the FPL, and without other substantial financial resources, and not eligible for Medicaid or other coverage, will be granted partial assistance.

Financial Poverty Level (FPL)			
Size of Family Unit	(Per Federal Register)	FPL times 200%	FPL times 350%
1	10,890	21,780	38,115
2	14,710	29,420	51,485
3	18,530	37,060	64,855
4	22,350	44,700	78,225
5	26,170	52,340	91,595
6	29,990	59,980	104,965
7	33,810	67,620	118,335
8	37,630	75,260	131,705
Each additional person	3,820	7,640	13,370
Discount Applicable		100%	% sliding scale

You must complete our application and provide the items listed below.

- 1) Paycheck stubs for the past month and/or statements of monthly benefits from Social Security.
- 2) Copies of your most recent 1040 federal income tax records, along with any schedules. If you did not file taxes, a statement from the Social Security office may be accepted in lieu of the federal income tax return.
- 3) Valid denial from the Illinois Department of Public Aid that there is no medical program to cover the patient.
- 4) Other information may be requested for further verification of you financial status.

If you are unable to provide any of the requested information, please attach a letter explaining the details. If you are currently unemployed, please include the date you were last employed.

If you have any questions, or need additional information, please contact Passavant's Credit Managers. Persons with last names A-K should call 217-245-9541, extension 3128. Persons with last names L-Z should call 217-245-9541, extension 3014.

Please return the application to Passavant Area Hospital, Patient Accounts Department, 1600 West Walnut, Jacksonville, IL 62650.

Failure to meet the above criteria provides grounds for denial of financial assistance. Providing false information may result in denial of financial assistance.

Financial Statement

Patient Name _____ Birth Date _____
Responsible Party _____ Telephone _____
Street _____ City _____ State _____ Zip _____
Number of Persons in Household _____

Income

Employer

Name _____
Address _____
City _____
How Long _____ Wages _____
Social Security Amt. _____
Unemployment Amt. _____
Alimony Amt. _____
Support Payments _____
Pension Amt. _____
Source _____
Other Income _____
Source _____
Total Income _____

Spouse's Employer

Name _____
Address _____
City _____
How Long _____ Wages _____
Social Security Amt. _____
Unemployment Amt. _____
Alimony Amt. _____
Support Payments _____
Pension Amt. _____
Source _____
Other Income _____
Source _____
Total Income _____

Assets

Savings _____ Institution _____
Checking _____ Institution _____

Real Estate

Home Address _____ Value _____
Mortgage Holder _____ Monthly Payment _____ Balance _____
Other Real Estate Address _____
Mortgage Holder _____
Value _____ Monthly Payment _____ Balance _____

Motor Vehicles

Make _____ Year _____ Make _____ Year _____

Other Assets

Liabilities

Rent

Name of Landlord _____

Address _____

Monthly Rent _____

Utilities

Company

Amount

Credit Cards

Credit Card

Payment

Balance

Other Debts

To Whom Owed

Payment

Balance

I certify that all of the information on this form is correct.

Signature _____ Date _____