Passavant AREA HOSPITAL
PHYSICIAN ASSOCIATION

1600 West Walnut
Jacksonville, IL 62650
(217) 479-5719

Financial Assistance and Uninsured Discount Program

RE: Passavant account #: Date:

Dear Patient/Guarantor:

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Passavant Area Hospital determine if you are eligible to receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the Passavant Area Hospital.

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 us 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 (217-245-2322) 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.

If you need assistance, please call us, 217-479-5719.

FINANCIAL APPLICATION

Please complete application completely and to the best of your knowledge.

Patient Information

Name (First, Middle, Last)	Date of Birth / /	Social Security Number Not Required	
Home Address (Include Apt#)	City	State	Zip Code
Was patient involved in an alleged accident? Yes ☐ No ☐		Preferred Phone Number ( )	
Is patient covered by other insurance programs? Medicare ☐ Medicaid ☐ Veterans Benefits ☐ Other ☐			

Applicant/Guarantor/Spouse/Partner Information

Name (First, Middle, Last)		Preferred Phone Number ( )	
Home Address (Include Apt#)	City	State	Zip Code
Employer's Name:		Employer's Phone : ( )	
Employer's Address	City	State	Zip Code

Family/Household Information

The number of persons in the patient's household:	
The number of the patient's dependents:	The ages of dependents:

Presumptive Eligibility Programs *(Please check for all that the patient qualifies)*

If you check any of the following boxes, you do not need to fill out the Gross Monthly Family Income section below.			
☐	Women, Infants & Children Nutrition Program (WIC)	☐	Incarceration in a penal institution
☐	Temporary Assistance for Needy Families (TANF)	☐	Homelessness
☐	Supplemental Nutrition Assistance Program (SNAP)	☐	Deceased patient with no estate
☐	Low Income Home Energy Assistance Program	☐	Religious order & vow of poverty
☐	Mental Incapacitation; no one to act on patient's behalf	☐	Recent personal bankruptcy
☐	Receives grant assistance for medical services	☐	IL Free Lunch & Breakfast Plan
☐	Medicaid Eligibility, but not on date of service or for non-covered service	☐	IHDA Rental Housing Program
☐	Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low income financial status as a criterion for membership (For example, Central Counties Health Centers)		

Gross Monthly Family Income *(Including cases where spouse/partner is guarantor or parent is guarantor for a minor)*

For verification purposes, documentation of family income from paycheck stubs (*copies of the two most recent)*, benefit statements, award letters, court orders, federal tax returns (*most recent*), or other documentation (*most recent W-2 and 1099 Forms*) must be provided by the patient.			
Wages	$	Veteran's disability	$
Self-employment	$	Private disability	$
Unemployment compensation	$	Worker's compensation	$
Social Security	$	Retirement Income	$
Social Security Disability	$	Child support/alimony	$
Veteran's pension	$	Other Income (Please Explain)	$

Additional Information Regarding Finances

For verification purposes, please include copies of last three months of the items listed below.			
Checking Account Balance	$	Stocks	$
Savings Account Balance	$	Mutual Funds	$
Health Savings/Flex Spending	$	Certificates of Deposit	$

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 of Patient or Applicant____Date ______________