Anderson Hospital

Date:

Re: Account (s):

Dear Patient,

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Anderson Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form and submit it to the hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care.

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.

Please submit proof of income (copies) for the entire household to process this application. Please use the following checklist and enclose all pertinent information:

- Proof of income – last three (3) paycheck stubs
- Last year's Federal Tax Return and W-2's
- Last two (2) statements for checking, savings, stocks, bonds, annuities, etc.
- Other information requested by Anderson Hospital (i.e. Medicaid denial letter, if applicable)

If you did not file taxes or you need a copy of your tax return, please contact the Internal Revenue Service (IRS) to request form 4506-T. You can obtain this form by calling the IRS at 1-800-829-1040, or going to the IRS website – http://www.irs.gov/pub.irs-pdf/f4506t.pdf and downloading a copy of this form. Or, you can visit the Patient Access department at Anderson Hospital and we can assist you in completing the form and faxing it directly to the IRS on your behalf. Once you have received the information from the IRS, please return the documentation received with the financial application with all the pertinent information in the envelope provided.

Completing the financial assistance application with the supporting documentation acknowledges your good faith effort to provide all the information requested to assist the hospital in determining whether you are eligible for financial assistance.

If you have any questions, please contact our Patient Access Financial Counselor at 618-391-6920. Our email address is – financialcounselor@andersonhospital.org, and our fax number is 618-288-9776.

Sincerely,

Anderson Hospital

Anderson Hospital

Anderson Hospital
6800 State Route 162
Maryville, IL 62062

Financial Assistance Application Account Number(s) if known: _____

1. Patient's Information

_____

Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

_____

Street Address *City* *State* *Zip Code*

_____

Mailing Address *City* *State* *Zip Code*

_____ _____

Home & Cell Phone Number *Work Phone Number* *Email address*

How long have you resided at this address? _____ Years _____ Months

If residency at current address has been less than six (6) months, please provide proof of residency (utility bill, lease, mortgage, etc.)

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Civil Union

2. Person Responsible for Paying the Bill (Guarantor, Partner or Spouse)

_____

Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

_____

Address if Different from Patient's *Home & Cell Phone Number* *Work Phone Number*

_____

Name of Insurance Company *Effective Date*

3. Please indicate ALL people living in the household, including applicant:

Use additional sheet of paper if needed

NAME *RELATIONSHIP TO PATIENT* *AGE* *SOCIAL SECURITY #* *DOCTOR'S NAME*

_____

_____

_____

_____

4. Is this application for future or past services? ☐ Future ☐ Past Dates of Services:_____

5. Were you an Illinois resident on the date of care? ☐ Yes ☐ No

6. Have you completed an Anderson Hospital Financial Assistance application within the last year? ☐ Yes ☐ No

7. In the last year, were you eligible for Medicaid benefits? ☐ Yes ☐ No

8. In the last year, did you receive food stamps, WIC or energy assistance? ☐ Yes ☐ No

9. Are you now unemployed? ☐ Yes ☐ No

   Please check all that apply: ☐ Unable to work ☐ Health Problems ☐ Student ☐ Injury ☐ Laid off ☐ Retired

10. Are you unable to work or go to school due to physical impairment? ☐ Yes ☐ No

If yes, what is the disabling condition or diagnosis?_____ How long will you be disabled?_____

11. Please check if anyone in your household is covered by: ☐ Health insurance ☐ Medicare ☐ Medicare Part D ☐ Medicare supplement ☐ Medicaid ☐ Veterans' benefits Which family member(s):_____

12. Are you divorced or separated or was a party to a dissolution proceeding, whether the former spouse or partner is financially responsible for your medical care per the dissolution or separation agreement? ☐ Yes ☐ No

13. Were you involved in an alleged accident? ☐ Yes ☐ No

14. Were you a victim of an alleged crime? ☐ Yes ☐ No

IF YOU MEET ANDERSON HOSPITAL'S PRESUMPTIVE ELIGIBILITY CRITERIA, YOU WILL BE NOTIFIED IN ADVANCE THAT YOU ARE NOT REQUIRED TO COMPLETE THE PORTIONS OF THIS APPLICATION ADDRESSING MONTHLY EXPENSE INFORMATION:

15. HOUSEHOLD INFORMATION	**APPLICANT**	**SPOUSE/PARTNER (If Applicable)**
NAME of household member:	_____	_____
Name of employer:	_____	_____
Employer address:	_____	_____
Employer telephone number:	_____	_____
Monthly Gross Income From:		
Employment :	$ _____	**$**_____
Self-employment:	$ _____	**$**_____
Workers' Compensation:	$ _____	**$**_____
Real Estate:	$ _____	**$**_____
Unemployment: (since ___/___/___)	$ _____	**$**_____
Retirement (Soc. Security, Pension):	$ _____	**$**_____
Veteran's pension, disability:	$ _____	**$**_____
Private Disability:	$ _____	**$**_____
Temp. Assistance. For Needy Families	$_____	$_____
Alimony/Child Support:	$ _____	**$**_____
Public Assistance/Food Stamps:	$ _____	**$**_____
Other Income:	$ _____	**$**_____
Checking, Savings and Investments:		
Checking Account Balances:	$ _____	**$**_____
Savings & CD Account Balances:	$ _____	**$**_____
IRAs, 403B, 401K, Stocks, Mutual Funds	$_____	$_____
Health Savings /Flexible Spending Acct:	$_____	$_____
Other Specify:_____	$ _____	**$**_____
Other:		
Automobile: Year, Make and Model	_____	_____
Recreational Vehicle: Year, Make and Model	_____	_____

16. HOUSEHOLD EXPENSES

Monthly Rent Payment $_____ or Mortgage Payment: $_____ Mortgage Loan Balance $_____

Do you own property other than a primary residence: ☐ Yes ☐ No If Yes, Value $_____ Mortgage balance $_____

If other property is a business, list address :_____

Monthly Loan Payment: _____ Paid to:_____ For:_____

Monthly Payments:

Utilities:	$_____	Insurance (Auto/Life Property)	$_____	Other:_____	$ _____
Alimony/Child Support	$_____	Health Insurance	$_____	Other:_____	$ _____
Child Care	$_____	Healthcare Bills	$_____	Other:_____	$ _____
Living (gas, food, clothes)	$_____	Medications	$_____	Other:_____	$ _____

17. OTHER SUPPORTING INFORMATION

Please describe your personal situation and your reasons for requesting assistance:

_____

_____

_____

_____

_____

If your financial assistance application is showing no income at all, please describe how you provide for your everyday living expenses such as housing, food, clothing, etc.:

_____

_____

_____

_____

_____

18. NEEDED DOCUMENTATION AND ASSIGNMENTS OF RIGHTS *Read Carefully*

You must provide copies of the following documents with the application.

Needed Documentation

_____ Proof of Income – last 3 paycheck stubs

_____ Last year's Federal Tax Return and W2's

_____ Last 2 statements for Checking, Savings, Stocks, Bonds, Annuities, etc.

_____ Other information requested by Anderson Hospital (i.e. Medicaid Denial letter if applicable)

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 granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Please return the completed application and all documentation to: Anderson Hospital, Patient Access Financial Counselor office at 6800 State Route 162, Maryville IL, 62062.

_____ _____

Applicant Signature Date Co-Applicant Signature Date

Please return application by:_____