

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

Table with 5 columns: 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 a 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 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

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 _____

UNINSURED PATIENTS ONLY:

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.

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 all 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: _____