FINANCIAL ASSISTANCE APPLICATION

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Community Memorial Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

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.

To apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care, please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax. In addition to this form a copy of the latest filed tax return, copies of last 3 paystubs, and last 2 months of bank statements will be required. The patient will also be required to apply for Medicaid. Additional documentation may be requested as determined by Community Memorial Hospital.

Patient Information						
Patient Name:				Social Security No		
			Phone Num	Phone Number		
Address:	Account No	_ Account No.				
Was the patient a resident of Illinois at the time of the services?						es / No
Were the services rendered due		Yes / No				
Were the services rendered due		Yes / No				
Is the patient homeless?					Ye	es / No
Is the patient now deceased with no estate?					Ye	es / No
Does the patient have a mental incapacitation with no one to act				et on patient's behalf? Yes / No		
Is the patient now eligible for M	es / No					
Guarantor Information (if dif	foront f	rom abova)				
			Social Secu	rity N	Jo	
Guarantor Name: Social Security No Address: Phone Number						
Address			FIIOHE Null	HUCI		
Family / Household Informati	on					
Please list all "family" members		rally this should	be all the people li	isted o	on the same tax return	as the patient.
Name	Age	Date of Birth	Relation to Patie	ent	Monthly Income	Source of Income / Employer
			Patient			
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Is there any additional informat	ion rega	arding your finar	ncial status that you	ı wou	ld like to add to this a	pplication?
Certification						
	this appl	lication is true ar	nd correct to the be	est of	mv knowledge. I will	apply for any state, federal or local
						ion provided may be verified by the
hospital, and I authorize the hos						
						nancial assistance, any financial
assistance granted to me may be						
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Cionatura			Doto		Polotion ship	
Signature			Date		Relationship	