Hammond-Henry HOSPITAL

CONFIDENTIAL APPLICATION FOR ASSISTANCE WITH PAYMENT OF MEDICAL BILLS

Please answer all questions with the proper answer or a zero if the question does not apply to you. Complete both pages of this application, attach additional sheet if necessary. Incomplete applications cannot be considered for payment and will be returned to you. Submit your completed application with a copy of the federal tax return you filed for last year's income. We cannot pay on accounts, which have been referred to a collection agency.

Name of Applicant: _____ Phone No.: (____)_____

Street/Mailing Address: _____

Birthdate: ____/____/____ Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Township of Residence: ❑ Atkinson ❑ Geneseo ❑ Munson ❑ Osco ❑ Other:_____

List the hospital bill for which you are completing this application. Please include date of service, account number and patient name.

Patient whose service incurred for:	What you owe as of this date:
_____	_____
_____	_____
_____	_____
_____	_____

Total Amount Applied For_____

The amount of this total you expect to be paid by insurance: _____

The amount you expect to be able to pay from your own resources: _____

If you have made payments on these bills, state total amount: _____

If insurance has paid on these bills, state total amount: _____

Did you have medical insurance when these bills were incurred? ❑ Yes ❑ No Do you now? ❑ Yes ❑ No

Name of your Hospital/Medical Insurance Company: _____

Name of Family Member for whom Charges were incurred: _____

Why was Medical Attention needed? _____

Birthdate if for child: ____/____/____

Total number in household (include yourself): Adults _____ Dependent Children _____

Are you presently employed? ❑ Yes ❑ No

Employer Name: _____ Phone No.: (____)_____

Employers Address: _____

How long have you been employed? _____ ❑ Full time ❑ Part time

If unemployed, how long have you been unemployed? _____

Who else in your household is employed? _____ Where?_____

How long have they been employed? _____ ❑ Full time ❑ Part time

Their employers phone number: (____)_____ If unemployed, how long has it been? _____

Total family take home pay you received last year. $_____

Total family take home pay you expect to receive this year. $_____

Other source(s) of income and total amount you expect to receive this year. $_____

Add lines (2) and (3), divide by 12 = your expected average monthly income. $_____

Your assets (what you own of value)

LIST FAIR MARKET VALUE

Home $_____

Farm $_____

Vehicle(s) Years/Models

_____

Savings $_____

Investments $_____

Other-describe, ie. raw land,

Cash value of life insurance, etc.

$_____

Your Liabilities

Mortgage $_____

Bank Loans (cars, etc.)

$_____

Charge Accounts $_____

Other $_____

Living expenses on a MONTHLY basis:

Rent or mortgage payment	$_____
Real estate taxes	$_____
Homeowners Insurance	$_____
Utilities	$_____
Food	$_____
Telephone	$_____
Medications	$_____
Car payments	$_____
Car Insurance	$_____
Gasoline	$_____
Life Insurance	$_____
Medical Insurance	$_____
Bank Loan Repayment	$_____
Charge Account Payments	$_____
Other bills (describe)	
_____	$_____
Total	$_____
Income less expense	$_____

All information above is to be kept confidential and is to be used for the sole purpose of providing sufficient information to the trustee to determine if I am eligible for aid or assistance in the payment of the costs of hospitalization, medicines, medical care and assistance as requested at the beginning of this application. I hereby give permission to any caregiver listed to release information to the trustee concerning their billings.

_____ _____

Spouse (signature) Date Applicant (signature) Date

Return this application, requested federal tax return, and a copy of the denial from the Illinois Department of Human Services directly to:

Lynette Owens, Financial Counselor
Hammond-Henry Hospital
600 N. College Avenue
Geneseo, IL 61254

Illinois Dept of Human Services
Kewanee: (309) 852-5627
Rock Island: (309) 794-9530
Whiteside: (815) 632-4045

If you have any questions please call (309) 944-9120 or email financialcounselor@hammondhenry.com