Hammond-Henry HOSPITAL

CONFIDENTIAL APPLICATION FOR ASSISTANCE WITH PAYMENT OF MEDICAL BILLS

Important: YOU MAY BE ABLE TO RECEIVE FREE AND DISCOUNTED CARE. Completing this application will help Hammond-Henry Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital within 60 days of discharge or receipt of hospital care.

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 sheets if necessary. Incomplete applications cannot be considered for payment and will be returned to you. We cannot review accounts which have been referred to a collection agency.

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

Guarantor of minor child _____

Street/Mailing Address: _____

Birthdate: ____/____/____ Email address: _____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

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

Is the Patient an Illinois Resident: ❑ Yes ❑ No

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_____

Did the patient have medical insurance when these bills were incurred? ❑ Yes ❑ No

Name of your Hospital/Medical Insurance Company: _____

Was the patient involved in an alleged accident? ❑ Yes ❑ No If yes, what type_____

Was the patient involved in an alleged crime? ❑ Yes ❑ No If yes, what: _____

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

Age of Dependent Children _____

Is the patient presently employed? ❑ Yes ❑ No

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

Employers Address: _____

Is the patient's spouse/partner employed? ❑ Yes ❑ No

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

Employers Address: _____

If the patient is a minor, are the parents/guardians employed? ❑ Yes ❑ No

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

Employers Address: _____

If the patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the application's section of monthly expenses.

Gross monthly family income from all sources $_____

Example: wages, self-employment, unemployment, social security, disability, Veterans' pension, workers compensation, child support, alimony, retirement income, other income

Your assets (what you own of value)

LIST FAIR MARKET VALUE

Home $_____

Farm $_____

Vehicle(s) Years/Models

_____

Savings $_____

Investments $_____

Other $_____

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 $_____

Homeowners Insurance $_____

Utilities $_____

Food $_____

Car Payments $_____

Car Insurance $_____

Gasoline $_____

Bank Loan Repayment $_____

Charge Account Payments $_____

Other bills (describe)

Total $_____

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 and any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.
I acknowledge that I have 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.

_____	_____	_____	_____
Applicant (signature)	Date	Spouse (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