



600 North College Ave. ~ Geneseo, IL 61254

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 90 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

The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.

Race: _____ Gender _____ Ethnicity _____

Preferred Language _____

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.: (____) _____

If the patient is a minor are the parents/guardians employed? Yes No Employer Name: _____

Phone No.: (____) _____

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.	\$ _____

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 Wignall, Financial Counselor
Hammond-Henry Hospital
600 North 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

Complaints or concerns with the uninsured patient discount application process or financial assistance process may be reported to the Health Care Bureaus of the Illinois Attorney General at:
Phone: 1.877.305.5145 [TTY 1.800.964.3013]
Website: <https://www.illinoisattorneygeneral.gov/consumers/healthcare.html>