Ferrell Hospital Community Foundation

FINANCIAL ASSISTANCE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Ferrell Hospital Community Foundation 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.

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.

Please complete this application and submit within 60 days following date of discharge or receipt of outpatient care to apply for free or discounted care.

Completed applications may be submitted as follows:

- In person to the Patient Financial Counselor
- Fax to at Ferrell Hospital Community Foundation 618-273-2504 Attn: Patient Financial Counselor
- By mail to: Ferrell Hospital Community Foundation / 1201 Pine Street / Eldorado, Il 62930 Attn: Financial Counselor

Questions may be directed to the Ferrell Hospital PFS department at (618)-273-3361 ext. 1663.

In order for Ferrell Hospital Community Foundation to process your application, all sections must be completed. In addition, we need the following supporting documents submitted with your application if they apply to you:

- Previous year's tax return
- Copy of the last 12 weeks of pay stubs for all household members' employment income
- Any other statements you receive from income sources (Social Security, alimony/child support, unemployment, retirement/pension, etc.)

SECTION ONE: APPLICANT INFORMATION
Please complete all of the below information regarding demographics and insurance information

Applicant Name: ______________________________________ Date of Birth: ____/____/________
LAST NAME FIRST NAME MIDDLE NAME

Address: ______________________ City: ______________ State: ______ Zip Code: __________

Phone Number: (   ) ______________________ Email: ____

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

Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Sex: ☐ Male ☐ Female
Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Chinese ☐ Arabic ☐ Russian ☐ Urdu

Marital Status: __Single __Married __Widowed __Divorced __Legally Separated __Other

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card.

☐ Yes ☐ No Insurance Company: ___________________________ Member ID: ____________________ Group Number: __________________

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.
Calculations for assistance approval are based on FAMILY INCOME only.
- For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			

SECTION THREE: INCOME INFORMATION

Provide list any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Wages/Salary		
Self-Employment		
Child Support/Alimony		
Social Security/Retirement		
Rental Income		
Unemployment		
Other Income		

BENEFITS RECEIVED:

Please check all benefits you currently receive: ____WIC ____SNAP ____LIHEAP ____ IL Free Lunch and Breakfast ____Grant Assistance for Medical Care ____IHDA Rental Housing Support

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified, and I authorize Ferrell Hospital Community Foundation 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, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant (Hospital Name Here) permission to contact me using any method provided on this application.

Signature of Applicant: ____ Date: _______________________________________

Spouse Signature (if applicable): ____ Date: _______________________________________

Maximum Collectible Amount

Patients with eligible expenses from Ferrell Hospital Community Foundation that exceed 20% of your family income are eligible for a discount under our Uninsured Patient Discount Policy. You may include health care expenses received in the last 12 months toward your Maximum Collectible Amount.

Questions or Concerns

If you have questions or concerns, you may contact Ferrell Hospital Community Foundation Financial Counseling Department by calling 618-273-3361 ext 1663 / 1664.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at: Website: https://www.illinoisattorneygeneral.gov/consumers/healthcare.html / Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)