



McDonough District Hospital Financial Assistance Application

Date: _____ Patient name: _____

Patient's phone number: _____ Patient Marital Status: _____

Person responsible for payment, if not patient: _____

Street: _____

City, State, Zip: _____

Date(s) of hospital service: _____ Account #(s): _____

➤ Do you have health insurance? Yes No
If you answered yes, please attach a copy of your insurance card.
Insurance _____

➤ Do receive any assistance from Macomb City Township? Yes No

Please check Financial Assistance Program you are applying for:

Financial Assistance *(Please complete Sections I, II and III)*

Fellheimer Assistance *(Please complete Sections I and III)*

If you answer yes to both of these, you may be eligible for Fellheimer Assistance.

- Were you age 62 or older on the date of your hospital services? Yes No
- Were you a resident of McDonough County for a minimum of one year prior to service? Yes No

Mammography Assistance Program *(Please complete Sections I and III)*

If you answer yes to both of these, you may be eligible for Mammography Assistance

- Are you having Breast or Mammography services? Yes No
- Have you been referred by the Illinois Department of Public Health? Yes No

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Section I – Income (All Applicants must complete)

Income includes wages, pensions, annuities, social security, retirement benefits, unemployment, worker’s compensation, child support or alimony. This list is not all inclusive.

	AGE	CURRENT INCOME PER MONTH \$	INCOME FOR PREVIOUS TWELVE MONTHS
Patient or Responsible Party		\$	\$
Spouse		\$	\$
Children that you and/or your spouse are supporting			

If you have reported \$0 income, please provide a brief explanation of how you (or the patient) are surviving financially. Continue on back if needed.

Section II – Assets (DO NOT COMPLETE if you are a Fellheimer or Mammography applicant)

LIQUID ASSETS	BANK/FINANCIAL INSTITUTION	BALANCE
Checking Account		\$
Savings Account		\$
Other: _____		\$
Other: _____		\$

OTHER ASSETS	\$ VALUE	\$ OWED	\$ EQUITY BALANCE
Home	\$	\$	\$
Rental Property	\$	\$	\$
Farm	\$	\$	\$
Other: _____	\$	\$	\$

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Section III – Certification

ATTACH A COPY OF THE FOLLOWING WITH YOUR APPLICATION. APPLICATIONS MAY BE RETURNED WITHOUT THIS INFORMATION:

- Most recent filed income tax return
- W-2(s) for responsible party/spouse
- Copies of recent pay/unemployment stubs
- Illinois Department of Public Aid Approval/Denial
- Social Security or Retirement Benefits statement
- Most recent bank statement for checking and or savings account(s)
- Copy of most recent property tax bill for Home, Rental Property and/or Farm

By my signature below, I certify that everything I have stated on this application and on any attachments is correct.

Applicant Signature

Date

Financial Counselor assisting patient filling out this application: _____

Contact phone: _____

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