Thank you for choosing McDonough District Hospital for your healthcare needs. McDonough District Hospital is committed to the community we serve. Our primary purpose is to provide high quality, cost-effective health services. Part of that commitment is complying with federal regulations and following sound financial policies in seeking reimbursement for the services that we provide. In addition, we recognize the need to provide assistance to those with financial concerns. For that reason, we have developed a Financial Assistance Program.

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help McDonough District 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.

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 form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has 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.

Section I – Patient Information (All Applicants must complete)

Date:_____ **Patient name:**_____

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

Patient Social Security Number (not required if you are uninsured):_____

Person responsible for payment, if not patient:_____

Street: _____

City, State, Zip: _____

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

More Than Hospital Care. . .A Hospital Caring.

Please check Financial Assistance Program you are applying for:

❑ Financial Assistance (Includes Uninsured Discount and Presumptive Eligibility)
(Please complete Sections I, II, III, IVand V)

❑ Fellheimer Assistance *(Please complete Sections I, II and V)*
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, II and V)*
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

➢ Do you have health insurance**? ❑ Yes ❑ No

➢ Do you have public aid (Medicaid)**? ❑ Yes ❑ No

If you answered yes to one of the above, please attach a copy of your insurance card or public aid card.
Insurance _____

*****Health Insurance coverage includes the following: Covered under a public or private health insurance, WIU Insurance or other health coverage including workers' compensation, accident liability insurance, or other third party liability.***

➢ Do receive any assistance from Macomb City Township? ❑ Yes ❑ No

➢ Are you homeless? ❑ Yes ❑ No

➢ Is the patient deceased with no known estate? ❑ Yes ❑ No

➢ Are you eligible for Food Stamps? ❑ Yes ❑ No
Please attach verification of your Food Stamp eligibility.

➢ Are you a resident of Illinois? ❑ Yes ❑ No
You may be asked for verification of your residency.

➢ Is the patient a WIU Student? ❑ Yes ❑ No

Section II – 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 had a recent change in income or reported $0 income, please provide a brief explanation of how you (or the patient) are surviving financially. Continue on back if needed.

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

LIQUID ASSETS		
Checking Account		$
Savings Account		$
Other: _____		$
Other: _____		$

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

Section IV – Documentation

ATTACH A COPY OF THE FOLLOWING WITH YOUR APPLICATION.

Income Verification:**

- ☐ Most recent filed income tax return AND/OR
- ☐ W-2(s) for responsible party/spouse AND/OR
- ☐ Copies of the 2 most recent pay/unemployment stubs AND/OR
- ☐ Written income verification from an employer if paid in cash AND/OR
- ☐ Social Security or Retirement Benefits statement (if direct deposited, copy of bank statement may be used for verification) AND/OR
- ☐ Unemployment compensation AND/OR
- ☐ Retirement income AND/OR
- ☐ Child support, alimony or other spousal support

Asset Verification:**

- ☐ 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 AND/OR
- ☐ Copy of most recent statement for Stocks, Certificates of deposit or Mutual Funds.

Other Documents:**

- ☐ Illinois Department of Public Aid Approval/Denial
- ☐ Food Stamp eligibility verification

Section V – Certification

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

_____ _____

Applicant Signature Date

Completed applications can be mailed to McDonough District Hospital, Attn: Financial Assistance Office, 525 E Grant Street, Macomb, IL 61455 or faxed to (309) 836-1532 or electronically mailed to billing@mdh.org. Questions regarding your bill or Financial Assistance can be directed to (309) 836-1528 or (309) 836-1529.