Sarah Bush Lincoln

Fayette County Hospital

FINANCIAL ASSISTANCE PROGRAM

At Fayette County Hospital, we are concerned about our patients and their families. We understand that healthcare expenses are often unexpected, and paying for services can be overwhelming. This is especially true if you do not have health insurance.

Here, we offer the Financial Assistance Program to all patients who show financial need. Fayette County Hospital has designated funds to aid patients who are unable to pay their obligation in full. Eligibility requirements have been set for those who request assistance. The guidelines are not meant to discourage anyone from seeking treatment. But are designed to ensure the hospital's resources are used for the people who need them most and who are the least able to pay. The financial information shared in this application will not be shared with anyone outside the hospital without your written authorization.

Applying for Financial Assistance

We want to assist you in finding the best possible solution for you and your family. Before applying for financial assistance, a Patient Account representative will first help you explore all possible options for financial assistance, including private insurance and public aid, where appropriate. Patients must then request a Financial Assistance Application. Along with the form, you must also provide copies the following financial information:

- **You must first apply for Illinois Public Aid**
- Your most recent federal and state income tax returns
- Your payment stubs from the past three months, or a written statement from your employer verifying your earnings for the past three months
- Your checking and savings account statements from the past three months
- Your monthly social security benefit statement and/or other monthly retirement statements. Unemployment/workers compensation check stubs
- Alimony/child support statements
- If you are currently unemployed and you and your family are without income, provide a letter from any person(s) providing you with support for your day-to-day expenses.

Note: Please do not submit original documents; they will not be returned.

Your Patient Accounts Representative can help you complete this form.

Eligibility Guidelines

Income guidelines for eligibility are adjusted annually based on the Federal Poverty Guidelines established by the United State Department of Health and Human Services and published periodically in the Federal Register.

These guidelines are subject to change without notice.

Your Financial Assistance amount will be based on your current account balance. You must contact our Business Office to include any new services and to update your Financial Assistance Application.

If you have any questions or concerns about your billing statement, or you require financial assistance, please contact our Business Office Patient Account Representative at **618-283-5443** Monday - Friday 8 am to 4 pm.

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Fayette County Hospital offers financial assistance to patients in need. Guidelines have been established to ensure the Hospital's limited resources are used to treat patients who are truly unable to pay and are not consumed by patients unwilling to pay or who have alternate pay sources.

CONFIDENTIAL FINANCIAL STATEMENT

Please complete this form, sign and date. Then return to Fayette County Hospital, Financial Assistance, Business Office, 650 West Taylor St., Vandalia, IL 62471

Patient's Name _____ Social Security Number _____

Address _____ Date of Birth _____

City, State, Zip _____ Phone Number _____

Guarantor's Name _____ Social Security Number _____
(Person responsible for bill, if other than patient)

Address _____ Phone Number _____

City, State, Zip _____ Alternate Phone Number _____
(Cell, Work, etc)

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er) ❑ Other

If other, please explain: _____

Number of people in household _____

Include ALL individuals living in a single resident

Students at college or prep school should be included if household provides support

DEPENDENTS

Name	Relationship	Date of Birth

For additional dependents, please attach on a separate sheet of paper.

Principle Residence: ❑ Own ❑ Rent ❑ Other

If Rent: Name of Landlord _____

Address _____

City, State, Zip _____

Rent Amount

$

If other, please explain _____
Example, live with parents, friend, in college, etc.

INCOME - Include all household members that are or will be listed on your tax return
Do not include income for minors

Wages - Current year W-2 and three check stubs/pay vouchers required

Name _____

Employer _____

Address _____

City, State, Zip_____

Employment Dates_____ to _____
(Month/Year) (Month/Year)

Indicate how paid and gross income

❑ Hourly ❑ Weekly ❑ Monthly ❑ Annual ❑ Other

Other - please explain: _____

$

Name _____

Employer _____

Address _____

City, State, Zip_____

Employment Dates_____ to _____
(Month/Year) (Month/Year)

Indicate how paid and gross income

❑ Hourly ❑ Weekly ❑ Monthly ❑ Annual ❑ Other

Other - please explain: _____

$

If multiple employers during year, list employers and wages on separate sheet of paper.

INCOME SOURCE

Farm or Self-Employment $_____
--Include applicable tax schedules

Public Assistance $_____
--Includes food stamps, circuit breaker, etc.

Unemployment Compensation $_____
--Indicate length of time, expected return date expectations of future employment

_____

Workers Compensation $_____
--Indicate length of time, expected return date expectations of future employment

_____

Housing Allowance $_____
--Rent-free housing provided by employer or organization

Other Allowances $_____
--Vehicle, utilities, food, etc. Provided by employer or organization

Child Support $_____

Alimony $_____

Military Family Allotment $_____

Pensions $_____
--Source

_____

Interest, Dividends, etc. $_____
--Source (including supporting documents)

Rent Income $_____
--Include rent expenses applicable to income

Social Security Benefits $_____

Other Income $_____

_____ $_____

_____ $_____

--Indicate Source

ASSETS

Please indicate asset value and any amounts that are still owed.

	Asset Value	Amount Owed	Monthly Payment
1. Value of Principle Residence - 1st Mortgage	$	$	$
- 2nd Mortgage	$	$	$
2. *Value of Secondary Residence Indicate type of residence and address Cabin, Vacation Home, Condo, Time Share, etc.	$	$	$
3. *Value of other property Indicate type of residence and address Rental property, lots, farm ground, investment property, etc.	$	$	$
	$	$	$
	$	$	$
4. Vehicles:			
1 - Year _____ Make _____	$	$	$
2 - Year _____ Make _____	$	$	$
3 - Year _____ Make _____	$	$	$
4 - Year _____ Make _____	$	$	$
5. *Boats, Recreational Vehicles, Motorcycles, TV's, Jet Skis, Campers, etc. Please indicate type of vehicle	$	$	$
	$	$	$
	$	$	$
6. Savings account balance	$		
Institution _____	$		
Institution _____			
7. Checking account balance	$		
Institution _____	$		
Institution _____			
8. *Investments	$		
Stocks, Bonds, CD, 401K, IRA's, etc.	$		
Indicate source _____	$		
9. *Other assets	$	$	$
Include farm and business equipment, etc.	$	$	$
Indicate asset _____	$	$	$

***Items 2, 3, 8 & 9 - Please provide a description of these items on a separate piece of paper.**

EXPENSES

For debts not listed elsewhere on application

	To Whom Owned	Amount Owned	Monthly Payment
Utilities			
Electric			
Gas			
Telephone - House			
Telephone - Cell			
Trash			
TV/Cable			
Water			
Sewer			
Food			
Medical Bills			
-Physician and /or facility name			
Hospitals			
Physicians			
Dentist			
Other			
Credit Cards			
-Indicate if balance in medical			
Property Taxes			
Insurance			
Gas/Vehicle Maintenance			
Other Debt			

*If additional debt, please include on a separate sheet of paper

This is to advise that I have pursued all other avenues possible, including private insurance and governmental and charitable agencies providing funding and relief from financial obligations, as well as Public Aid. Therefore, I hereby request that Fayette County Hospital make a determination of my eligibility for the Financial Assistance Program. I understand that the information that I submit concerning my income, household size, assets and expenses and medical bills is subject to verification by Fayette County Hospital personnel. I also understand that if the information that I submit is now or at any time in the future is determined will result in current and/or retroactive denial of financial assistance and that I will be liable for services rendered.

I further understand that this financial information will not be shared with anyone outside the hospital without my written authorization.

I certify that all the information in this form is true and correct

Guarantor Signature _____ Date _____

Spouse Signature _____ Date _____