Ferrell Hospital
DEACONESS ILLINOIS PARTNER

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 can be submitted as follows:

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

Questions can be directed to the Ferrell Hospital PFS department at (618)-273-3361 ext 381 or 383.

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.

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ DATE OF BIRTH: ____/____/____ SSN: _____/_____/_____
(First Name) (Middle Initial) (Last Name (Not required if you are uninsured)

ADDRESS: _____ _____ _____ _____
(Address/PO Box) (City) (State) (Zip Code)

PHONE NUMBER: (_____) - _____ - _____ EMAIL: _____

MARITAL STATUS: ___Single ___Married ___Widowed ___Divorced ___Legally Separated ___Other
(Please Check)

I have received Financial Assistance from Ferrell Hospital Community Foundation within the last 12 months: _____YES _____NO

Was the patient an Illinois resident when care was rendered? YES _____ NO _____ Was the patient involved in an accident? YES _____ NO _____
Was the patient a victim of an alleged crime? YES _____ NO _____ Does the patient have any health insurance? YES _____ NO _____

***FAMILY / HOUSEHOLD INFORMATION*:**

Number of persons in the patient's family/household: _____ Number of patient's dependents: _____

Ages of patient's dependents: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

EMPLOYMENT AND INCOME INFORMATION:

Please enter the employer information for patient, spouse/ partner, and/or parent/guardian below. If the patient is a minor, enter the employer information for the patient's parents or guardians.

PATIENT	SPOUSE/PARTNER	PARENT/GUARDIAN
Employer Name:	**Employer Name**	**Employer Name**
Address:	**Address:**	**Address:**
City, State, Zip	**City, State, Zip**	**City, State, Zip**
Gross Monthly Salary: $	**Gross Monthly Salary: $**	**Gross Monthly Salary: $**

OTHER MONTHLY INCOME

OTHER MONTHLY INCOME	*PATIENT*	*SPOUSE/PARTNER/OTHER DEPENDENT*
Wages / Self Employment Income	$	$
Unemployment Compensation	$	$
Worker's Compensation	$	$
Social Security	$	$
Disability Income: SSI/Veterans/Other	$	$
Retirement Income: Pension/Ira/Other	$	$
Child Support/Other Dependent Support Received	$	$
Alimony / Other Spousal Support	$	$
Interest / Dividend Income	$	$
TANF: Temporary Assistance Needy Family	$	$
Rental or Property Income	$	$
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

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I *certify the information in this application is true and correct to the best of my knowledge. I will apply for any federal, state, or local assistance for which I may be eligible to help pay for these medical bills.*

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 false information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and <u>I will be responsible for payment of these medical bills</u>.

Signed: _____ **Date:** _____

Signed: _____ **Date:** _____

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PATIENT FINANCIAL HELP FORM

This statement is to be completed and signed by the person(s) <u>assisting</u> you with your living and financial expenses.

PATIENT NAME: _____ _____ _____
(First Name) (Middle Initial) (Last Name

NAME : _____
(Person Assisting Patient)

ADDRESS: _____

PHONE NUMBER: (_____) - _____ - _____

RELATION OF PERSON TO YOU: _____

What type of assistance is currently being provided (check all that applies)?

☐ **Financial Assistance**

☐ **Food**

☐ **Shelter**

☐ **Other**: _____
(Please explain)

Estimated dollar amount provided in the last 30 days: $ _____

Signature of Person Providing Patient Assistance: _____ **Date:** _____

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EMPLOYEE WAGE FORM

To be completed and signed by employer if unable to provide copies of employment income for last 90 days.

EMPLOYEE NAME: _____ _____ _____ EMPLOYEE SSN: _____/____/_____
(First Name) (Middle Initial) (Last Name) (Not required if uninsured)

EMPLOYER NAME: _____

EMPLOYER PHONE NUMBER: (_____) - _____ - _____ EXT: _____

EMPLOYER ADDRESS: _____ _____ _____ _____
(Address/PO Box) (City) (State) (Zip Code)

WAGES FOR THE LAST 90 DAYS OR 3 MONTHS

WEEK	PAY PERIOD ENDING	GROSS WAGES
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. **Is the employee currently working? ____YES ____NO If NO, when was the last day worked? _____**
2. **If the employee is not currently working, will the employee be returning to work? ____YES ____NO**
3. **Expected return date _____**

I certify the wage information regarding the person named above is true and accurate.

Employer/Employer Representative Signature: _____ Date: _____

Ferrell Hospital Community Foundation

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

HOUSEHOLD INFORMATION:

Number of persons in the patient's family/household shall exclude any non-minor children, living at home but not claimed on the parents' tax return, who are required to apply separately for financial need. Number of dependents includes those that are claimed on your tax return. You will be required to submit a copy of your most recent tax return to support the number of claimed household dependents. A non-minor child still living in the parent's household, and not claimed on the parent's tax return, shall apply for financial need separately based on his/her own income and not that of the parents. If the non-minor child is claimed on the parent's tax return, then the parents' income should be factored in to the household income for financial need determination.

MONTHLY EXPENSES:

Since monthly expenses are not factored in to Ferrell Hospital Community Foundations determination of financial need eligibility, the patient is not required to submit other monthly expense data as part of this application process unless it becomes necessary to help validate the applicant's income. The patient is required to submit outstanding current medical expenses in order to aid in the determination of medically indigent status.

MEDICAID ASSISTANCE:

Applicants who are determined to be potentially eligible for Medicaid coverage are required to apply for Medicaid assistance to determine eligibility under the State Medicaid system prior to determining eligibility for the Uninsured Patient Discount and Financial Assistance Programs. Medicaid co-pays are still collectible and payable regardless of financial need qualification.

INDEPENDENT PHYSICIAN FEES ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE: Independent physicians providing services at Ferrell Hospital Community Foundation, including but not limited to Pain Management, radiologists, pathologists, bill for their services separately. This Hospital Financial Assistance application does not cover nor apply to fees charged by those independent physicians.

FERRELL HOSPITAL FAMILY PRACTICE/ELDORADO FAMILY MEDICINE/CARMI FAMILY MEDICINE: FHFP and EFM are hospital based rural health clinics operated under Ferrell Hospital Community Foundation. CFM is a provider based clinic operated under Ferrell Hospital Community Foundation. Eligibility for financial need assistance as determined through this Patient Financial Assistance application will apply to services billed through any of Ferrell Hospital's provider based clinics.

ATTACHMENTS: If you do not have access to a copier, feel free to bring in your original supporting documentation when returning this completed application and we will be happy to make the necessary copies for you.

NOTIFICATION AND APPROVALS: Notification of approval or request for additional information will be provided to you within approximately 2 weeks of returning the application with all completed documentation. Any approved financial need expires six (6) months from the approval date. Upon expiration of the approval, applicant will be asked to complete a new application form to update on the current financial status and any changes thereof.

Our Financial Counselors are located at our facility to assist you in person Monday thru Friday from 7AM to 5:30PM excluding holidays.

Financial Counselors may be reached by phone: (618)-273-3361 ext 381 or 383.