

**MEMORIAL HOSPITAL  
1900 STATE ST.  
CHESTER, IL 62233  
618-826-4581**

Dear Patient/Guarantor,

Attached, are application papers for the Uncompensated/Charity Care and Uninsured Discount financial assistance programs offered by Memorial Hospital, Chester IL.

**Please be aware that all sources of payment must be exhausted before financial assistance is considered.** Examples of payment would be all medical insurance, third party and liability claims, Dept of Health Care & Family Services, and other types of coverage.

**If you wish to apply for these programs, please read, complete, sign, and date the application forms.**

**You must supply the following information:**

- A copy of acceptance or valid denial from the Illinois Dept of Health Care and Family Services (formerly know as the Illinois Dept. of Public Aid).
- Copies of check, check stubs or proof of direct deposit for employment, Social Security, pension, unemployment, workers compensation or any other source(s) of income received in the past 30-90 days.
- A copy of most recent complete federal tax return. If self employed must include Schedule C.

**Application along with necessary documentation/forms must be returned within 60 days.**

**Please be as accurate as possible when filling out the application form. Once the application has been turned in no changes will be allowed.**

**Please Note: Completing and submitting the application for Uncompensated/Charity Care or Uninsured Discount program does not automatically relieve you of your financial obligation to Memorial Hospital, Chester IL.** Memorial Hospital, Chester IL reserves the right to deny any application upon their review.

Patient Accounts Department  
Memorial Hospital, Chester IL

**MEMORIAL HOSPITAL  
1900 STATE ST.  
CHESTER, IL 62233**

**UNCOMPENSATED/CHARITY CARE POLICY**

Memorial Hospital will give uncompensated/charity care to those who require care that is medically necessary, but are unable to pay. This uncompensated/charity care will be available to all persons without discrimination based upon race, color, national origin, creed or other grounds unrelated to the individuals need for the medically necessary services of this facility. A request for financial assistance under this policy must be made by or on behalf of the patient.

Uncompensated /charity care may be given in full or part based upon the applicant's financial situation and/or ability to pay. Criteria for uncompensated/charity care will be based upon 100% of the Federal Poverty Level Income Guidelines for persons who do not qualify for any state healthcare assistance program(s). Partial discounts will be assessed based upon up to 200% of the Federal Poverty Level Income Guidelines. Applicants may qualify based upon individual or unusual circumstances. Each applicant will be assessed based on need and financial situation.

Persons requiring medically necessary care may request a determination of their eligibility for uncompensated /charity care prior to the service, after the service is provided, or even after collection action has begun. Memorial Hospital, reserves the right to require proof of financial need. This requirement may be but not limited to proof of income, listing of assets, denials from public assistance program(s), tax returns or any other information that is necessary to substantiate the applicant's income and ability to pay. In addition Memorial Hospital requires an application for the uncompensated /charity care be completed, signed and returned to the Patient Accounts Department.

**UNINSURED PATIENT DISCOUNT**

Memorial Hospital provides an Uninsured Patient Discount program for medically necessary services provided to patients with no insurance. Applicants must meet certain eligibility criteria. This discount program is only available to residents of the State of Illinois and is based on family income.

Memorial Hospital, Chester IL, reserves the right to verify proof of financial need which may include investigation services provided by an outside agency. Memorial Hospital reserves the right to automatically deny an application if information provided is found to be false or if requested information necessary to process application is not provided.

I have read the policy regarding the uncompensated care/charity care program provided by Memorial Hospital, Chester, IL. I agree to complete the necessary application form and provide the financial information necessary for Memorial Hospital to make a determination as to my eligibility for this program. I understand that the completed, signed application and necessary information must be returned to the hospital's Patient Accounts Department before a determination of eligibility for the program can be made. I also agree that if I do not qualify for uncompensated/charity care or only qualify for a partial discount, I will cooperate with Memorial Hospital to establish a reasonable payment plan for any balances I may owe and I will make a good faith effort to honor said payment plan. I also understand that if the information I provide is found to be false, my application for uncompensated care/charity care will be automatically denied without further consideration.

Dated: \_\_\_\_\_

Applicant Name (printed): \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

**Memorial Hospital  
1900 State St.  
Chester, IL 62233**

**APPLICATION FOR UNCOMPENSATED CARE AND/OR UNINSURED DISCOUNT PROGRAM**

**Applicant Information:**

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Last name	First Name	Middle Initial
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Address	City	State	Zip	County
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Mailing Address (if different than above)

**Please list the name of the Patient(s) and the relationship to the applicant for which you are applying. If more space needed, please use the back of this page. If the application is for a deceased person please give the name and date of death.**

Patient:	Relationship:
<hr/>	<hr/>
<hr/>	<hr/>

**Please list Full Name, Birth Date, Social Security Number, and Relationship of all Persons residing with you, the applicant. If more space needed, please use the back of this page.**

Name:	Birth Date:	SS#:	Relationship:
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**A copy of acceptance or valid denial from the Illinois Dept of Health Care and Family Services (formerly know as the Illinois Dept. of Public Aid) or your State's Public Assistant Program is required.**

Do you have any health insurance coverage?  Yes  No

Do you have current Medicaid/HFS coverage:  Yes  No

If you have coverage, please provide most recent Medicaid/HFS card.

Have you applied for Medicaid?  Yes Date applied: \_\_\_\_\_  No

If denied, date of denial \_\_\_\_\_. **A COPY OF THE MEDICAID DENIAL LETTER MUST BE ATTACHED TO THE APPLICATION.**

**If anyone in your household is currently employed or has been employed within the last 3 months, please complete the following** (If more than 2 persons in household employed, please list information on a separate page):

**Name:** \_\_\_\_\_ **Position/Title:** \_\_\_\_\_

Employer Name (if self employed enter "Self"): \_\_\_\_\_

Employers Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

# Hours Worked Weekly: \_\_\_\_\_ How Often Paid: \_\_\_\_\_ How Much :\$ \_\_\_\_\_

**Name:** \_\_\_\_\_ **Position/Title:** \_\_\_\_\_

Employer Name (if self employed enter "Self"): \_\_\_\_\_

Employers Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

# Hours Worked Weekly: \_\_\_\_\_ How Often Paid: \_\_\_\_\_ How Much :\$ \_\_\_\_\_

**If unemployed, name of last employer, how long unemployed, reason for unemployment:** \_\_\_\_\_  
\_\_\_\_\_

**INCOME: If anyone in your household has received money from any of the sources listed below in the last 60 days, please check source from which money came. Please fill in the amount(s) received per month:**

\_\_\_\_\_ Employment Wages \$ \_\_\_\_\_ \_\_\_\_\_ Self Employment or Farm income \$ \_\_\_\_\_

\_\_\_\_\_ Unemployment Benefits \$ \_\_\_\_\_ \_\_\_\_\_ Social Security Benefits \$ \_\_\_\_\_

\_\_\_\_\_ Pension or Retirement Fund \$ \_\_\_\_\_ \_\_\_\_\_ Workers Compensation \$ \_\_\_\_\_

\_\_\_\_\_ Child Support/Alimony \$ \_\_\_\_\_ \_\_\_\_\_ Tax refund \$ \_\_\_\_\_

\_\_\_\_\_ Veterans Benefits \$ \_\_\_\_\_ \_\_\_\_\_ Strike and/or Union Benefits \$ \_\_\_\_\_

\_\_\_\_\_ Sick Pay/Deferred Compensation \$ \_\_\_\_\_ \_\_\_\_\_ Rent from Roomers/Boarders \$ \_\_\_\_\_

\_\_\_\_\_ Military Family Allotments \$ \_\_\_\_\_ \_\_\_\_\_ Public Aid (including Food Stamps) \$ \_\_\_\_\_

**Do you pay child support?** \_\_\_\_\_ yes \_\_\_\_\_ no **Amount you pay each month \$** \_\_\_\_\_.

**NOTE: Proof of the amounts listed above MUST BE SUBMITTED along with the application. Examples are, but not limited to copies of pay check and/or stubs, proof of direct deposit, W-2 Forms, unemployment or disability statements, etc. A copy of the most recent year's Federal Income Tax return is also required .** \_\_\_\_\_ **I don't file income taxes. Reason:** \_\_\_\_\_

**If no income listed, please explain how living expenses are being paid:** \_\_\_\_\_  
\_\_\_\_\_

**At any time during the 60 days prior to application or at present do you or anyone in your household have any of the following assets? Check all that apply. Fill in the current balance or value of the asset. Proof of amount(s) may be required:**

\_\_\_ Checking Account. Current balance: \$ \_\_\_\_\_      \_\_\_ Stocks/Bonds/Mutual Funds. Value: \$ \_\_\_\_\_  
\_\_\_ Savings Account. Current balance: \$ \_\_\_\_\_      \_\_\_ Trust Fund. Value :\$ \_\_\_\_\_  
\_\_\_ Money Market. Current Value: \$ \_\_\_\_\_      \_\_\_ IRA, 401K. Current balance: \$ \_\_\_\_\_  
\_\_\_ Oil, Coal, Gas or Mineral Rights \$ \_\_\_\_\_      \_\_\_ Other (Certificate of Deposit, Etc) \$ \_\_\_\_\_

**Do you own any of the following:**

\_\_\_ Automobile(s), Motorcycle(s), ATV(s): List make, model and year of all owned: \_\_\_\_\_  
\_\_\_\_\_ Approx Total Value: \$ \_\_\_\_\_

\_\_\_ Trailer, Motor Home, Camper, Boat(s). List make, model and year of all owned: \_\_\_\_\_  
\_\_\_\_\_ Approx Total Value: \$ \_\_\_\_\_

**Do you:** \_\_\_ Rent    \_\_\_ Own/Buying your home.

If own/buying, please list: Home Value \$ \_\_\_\_\_ Current Mortgage \$ \_\_\_\_\_

\_\_\_ Own or buying other property. Please list property Value \$ \_\_\_\_\_ Current Mortgage \$ \_\_\_\_\_

**Briefly, explain the reason you are applying for the Uncompensated Care and/or Uninsured discount program offered by Memorial Hospital, Chester IL:** \_\_\_\_\_  
\_\_\_\_\_

**I hereby request that Memorial Hospital, Chester IL, make a determination as to my eligibility for Charity Care/Uninsured patient discount program. I affirm that the information given on this application is true and correct to the best of my knowledge. I consent to any investigation made by Memorial Hospital, Chester IL, or their representing agencies, to verify the information I have given. I also understand that if the information I have given is found to be false, such findings will result in an automatic denial for Charity Care/Uninsured patient discount program, and that I will be liable for charges for services provided.**

**Date:** \_\_\_\_\_

**APPLICANT NAME (PRINT):** \_\_\_\_\_

**APPLICANT SIGNATURE:** \_\_\_\_\_

**HOSPITAL USE ONLY: DATE RECEIVED:** \_\_\_\_\_ **By:** \_\_\_\_\_