MEMORIAL HOSPITAL
Since 1962
Chester, Illinois

Memorial Hospital
1900 State Street
Chester, Illinois, 62233

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Memorial Hospital to process your application, all sections must be completed. Also, we need the following supporting documents submitted with your application if they apply to you:

- Previous year's tax return
- Copy of three (3) most recent pay stubs for all household members' employment income
- Most recent bank statements
- Any other statements you receive from income sources (Social Security, alimony/child support, unemployment, retirement/pension, etc.)
- A copy of recent (within last 6 months) acceptance or valid denial from your state's Public Aid Program (NOT APPLICABLE FOR RURAL HEALTH CLINIC SLIDING FEE DISCOUNT PROGRAM)

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Applicant Name: _____ Date of Birth: ___/___/___
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number:( ) _____ Email: _____

The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.

Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Sex: ☐ Male ☐ Female
Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Chinese ☐ Arabic ☐ Russian ☐ Urdu

Did you have health insurance at the time of your service? Yes ☐ No ☐ Insurance Company: _____

If no, have you applied for Medicaid? ☐ Yes ☐ No
If yes, what is the status of your Medicaid application? ☐ Approved ☐ Denied ☐ Pending

Please note: A copy of recent acceptance or valid denial from Medicaid is REQUIRED if applying for Hospital Financial Assistance Program. A copy of recent acceptance or valid denial from Medicaid is NOT REQUIRED if applying for Rural Health Clinic Sliding Fee Scale Discount Program ONLY.

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.
- For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

SECTION THREE: INCOME INFORMATION
Please list any income that members of your household receive.

Income Source	Hourly Wage or Monthly Income – Applicant	Hourly Wage or Monthly Income – Spouse/Other
Wages/Salary		
Self-Employment		
Child Support/Alimony		
Social Security/Retirement		
Rental Income		
Unemployment		
Other Income		

SECTION FOUR: ASSETS INFORMATION
Please list the following Note: Asset Information is NOT REQUIRED if applying ONLY for Rural Health Clinic Sliding Fee Scale Discount Program

Asset Type	Current Balance – Applicant	Current Balance – Spouse/Other
Bank Account – Savings		
Bank Account – Checking		
Health Savings Account/FSA		

Briefly explain the reason you are applying for Financial Assistance: _____

_____

_____

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified, and I authorize Memorial Hospital 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 medical bill(s). I grant Memorial Hospital permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____

Spouse Signature (if applicable): _____ Date: _____

Maximum Collectible Amount
Patients with eligible expenses from Memorial Hospital that exceed 20% of your family income are eligible for a discount under our Uninsured Patient Discount Policy. You may include health care expenses received in the last 12 months toward your Maximum Collectible Amount.

Questions or Concerns
If you have questions or concerns, you may contact Memorial Hospital's Patient Accounts Department by calling 618-826-4581 ext. 1484.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at:
Website: https://www.illinoisattorneygeneral.gov/consumers/healthcare.html Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)