



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

#### 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.		
1		

**Memorial Hospital, Chester, IL**

**Application for Financial Assistance**

**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:**

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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](tel:1-877-305-5145) (TTY [1-800-964-3013](tel:1-800-964-3013))