Hospital Sisters
HEALTH SYSTEM

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
St. Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

Sponsored by the Hospital Sisters of St. Francis

FINANCIAL ASSISTANCE APPLICATION

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Hospital Sisters Health System determine if you can receive free or discounted services or other public programs that can help pay for your health care. 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 is not required, but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

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.

CERTIFICATION STATEMENT

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided in this application may be verified to ensure accuracy. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, and financial assistance grated to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or Applicant Signature: _____ Date:_____

FINANCIAL ASSISTANCE PROGRAM

Please provide copies of the following items:

- ❑ W-2 withholding statements
- ❑ Most recent federal/state income tax forms
- ❑ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).
- ❑ Forms approving or denying Unemployment, Workers Compensation or Assistance from the Department of Public Aid
- ❑ Statement of annual benefits from Social Security
- ❑ Checking/savings account statements (past 3 months)
- ❑ Other: letter explaining your situation

Your cooperation with Hospital Sisters Health System (HSHS) is extremely important in determining your eligibility for financial assistance. Failure to provide this information will be cause to deny financial assistance.

Please return completed application along with required documentation to the hospital where you received your medical care:

WISCONSIN

EASTERN WISCONSIN

St. Mary's Hospital – Green Bay, WI
St. Vincent Hospital – Green Bay, WI
St. Nicholas Hospital – Sheboygan, WI

All **Eastern Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
Attention: Financial Assistance Program
PO Box 13508
Green Bay, WI 54307

Local – (920) 433-8122
Toll free – (800) 211-2209
Fax – (920) 431-3161

WESTERN WISCONSIN

St. Joseph's Hospital - Chippewa Falls, WI
Sacred Heart Hospital - Eau Claire, WI

All **Western Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
Attention: Financial Assistance Program
900 W. Clairemont Avenue
Eau Claire, WI 54701

Local - (715) 717-4141
Toll free - (888) 445-4554
Fax - (715) 717-4032

ILLINOIS

CENTRAL ILLINOIS

St. John's Hospital – Springfield, IL
St. Francis' Hospital – Litchfield, IL
St. Mary's Hospital – Decatur, IL
St. Mary's Hospital – Streator, IL

All **Central Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
Attention: Financial Assistance Program
2343 South MacArthur Blvd.
Springfield, Illinois 62704

Local – (217) 525-5615
Toll free – (888) 477-4221

SOUTHERN ILLINOIS

St. Elizabeth's Hospital – Belleville, IL
St. Joseph's Hospital – Highland, IL
St. Anthony's Hospital – Effingham, IL
St. Joseph's Hospital – Breese, IL

All **Southern Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
Attention: Financial Assistance Program
211 South Third Street
Belleville, IL 62220

Local – (618) 234-8600

FINANCIAL ASSISTANCE APPLICATION

APPLICANT/RESPONSIBLE PARTY INFORMATION

APPLICANT NAME: (last, first, middle initial)

BIRTH DATE:	SOCIAL SECURITY NUMBER:	PHONE NUMBER:

HOME ADDRESS (City, State, Zip):

PREVIOUS ADDRESS (City, State Zip):

Members of family unit	HOUSEHOLD MEMBER NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT *If Applicant, Self*	Live at home Yes	Live at home No	SOCIAL SECURITY NUMBER	Current Patient? Yes	Current Patient? No
1.								
2.								
3.								
4.								
5.								

PRESUMPTIVE ELIGIBLITY CRITERIA:

Does any of the information below apply to you? If YES, check all that apply Please provide documentation/verification if you check YES to any of the statements below:

- ❑ Homelessness
- ❑ Deceased with no estate
- ❑ Mental incapacitation with no one to act on patient's behalf
- ❑ Medicaid eligibility, but not on date of services or for non-covered service
- ❑ Incarceration in penal institution
- ❑ Enrolled in Temporary Assistance for Needy Families (TANF)
- ❑ Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
- ❑ Enrolled in Wisconsin Department of Health Services Housing Assistance Program

Enrollment in the following assistance for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

- ❑ Woman, Infants and Children Nutrition Program (WIC)
- ❑ Supplemental Nutrition Assistance Program (SNAP)
- ❑ Illinois Free Lunch and Breakfast Program
- ❑ Wisconsin Free Lunch Program
- ❑ Low Income Home Energy Assistance Program (LIHEAP)
- ❑ Wisconsin Home Energy Assistance Program (WHEAP)
- ❑ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
- ❑ Receipt of grant assistance for medical services

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veteran's benefits, Medicaid and/or Medicare? If yes, please provide the following information:

Policy holder: _____

Insurer: _____ Policy number: _____

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

Were you covered or eligible under a spouse/partner or former spouse/partner's health insurance policy, foreign coverage policy, Health Insurance Marketplace policy, Veteran's benefits, Medicaid and/or Medicare policy for any or all of your medical services?

Former spouse/partner name: _____ Phone number:_____

Former spouse/partner address: _____

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

EMPLOYMENT 1: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):

SALARY (GROSS): PERIOD: ❑WEEKLY ❑BI-WEEKLY $ _____ (AMOUNT) ❑TWICE A MONTH ❑MONTHLY ❑ANNUALLY	HOW LONG: _____ YR _____ MO	POSITION:

EMPLOYMENT 2: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):

SALARY (GROSS): PERIOD: ❑WEEKLY ❑BI-WEEKLY $ _____ (AMOUNT) ❑TWICE A MONTH ❑MONTHLY ❑ANNUALLY	HOW LONG: _____ YR _____ MO	POSITION:

UNEARNED INCOME
Child support does not need not be revealed if you do not wish to have it considered as a basis for repaying this obligation.

	TYPE OF UNEARNED INCOME	HOUSEHOLD MEMBER	AMOUNT	PERIOD
1.				
2.				
3.				
4.				
5.				

HOME: ❑ Rent ❑ Own	NAME AND ADDRESS OF LANDLORD	RENT PMT: $	DUE DATE:	CONTRACT PMT: $	MORTGAGE PMT: $
		PURCHASE PRICE: $	DATE PURCHASE:	BALANCE DUE: $	ESTIMATED VALUE: $

ASSETS/RESOURCES

	TYPE OF ASSET	HOUSEHOLD MEMBER	AMOUNT	PERIOD	BANK/ DESCRIPTION
1.					
2.					
3.					
4.					
5.					

CREDIT/RECURRING ACCOUNTS

NAME AND ADDRESS OF CREDITOR	WHAT WAS PURCHASED?	AMOUNT FINANCED	UNPAID BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				
4.				

Are you seeking financial assistance for treatment related to:

❑ Workplace injury ❑ Accident ❑ Crime ❑ Cancer

If yes, please provide details: _____

_____

_____

_____