Hospital Sisters
HEALTH SYSTEM

Breese, IL
HSHS St. Joseph's Hospital

Decatur, IL
HSHS St. Mary's Hospital

Effingham, IL
HSHS St. Anthony's Memorial Hospital

Greenville, IL
HSHS Holy Family Hospital

Highland, IL
HSHS St. Joseph's Hospital

Litchfield, IL
HSHS St. Francis Hospital

O'Fallon, IL
HSHS St. Elizabeth's Hospital

Shelbyville, IL
HSHS Good Shepherd Hospital

Springfield, IL
HSHS St. John's Hospital

Chippewa Falls, WI
HSHS St. Joseph's Hospital

Eau Claire, WI
HSHS Sacred Heart Hospital

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

Oconto Falls, WI
HSHS St. Clare Memorial Hospital

Sheboygan, WI
HSHS St. Nicholas Hospital

HSHS Medical Group

Prairie Cardiovascular

www.hshs.org

Sponsored by Hospital Sisters Ministries

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 Number 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 granted 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 that are applicable:

- ❑ Current year W-2 withholding statements
- ❑ Most recent complete federal/state income tax forms including schedules
- ❑ 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
- ❑ Complete Checking/Savings account statements (past 3 months)
- ❑ Health Savings Account Statement (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 within 30 days of receipt to the following address:

Patient Financial Services
Attention: Financial Assistance Program
P.O. Box 13508
Green Bay, WI 54307

Telephone Toll Free: 1 (800) 211-2209
Fax: (920) 431-3161
Email: PatientFinancialServices@hshs.org

HSHS St. Mary's Hospital Medical Center - Green Bay, WI
HSHS St. Vincent Hospital – Green Bay, WI
HSHS St. Clare Memorial Hospital - Oconto Falls, WI
HSHS St. Nicholas Hospital – Sheboygan, WI

FINANCIAL ASSISTANCE APPLICATION

APPLICANT/RESPONSIBLE PARTY INFORMATION

APPLICANT NAME: (last, first, middle initial)

BIRTHDATE: SOCIAL SECURITY NUMBER: PHONE NUMBER:

(Optional) RACE: (Optional) ETHNICITY: (Optional) SEX: (Optional) PREFERRED LANGUAGE:

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 - shelter
- ❑ 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)
- ❑ 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: _____

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: _____

EMPLOYMENT 1: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):	
SALARY (GROSS): _____(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ 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): _____(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ TWICE A MONTH ❑ MONTHLY ❑ ANNUALLY	HOW LONG: _____YR_____MO	POSITION:

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

☐ Please check box if you do not currently file taxes.

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

CHILD SUPPORT: NAME OF CHILD (RECEIVING)	NAME OF PERSON / PARENT PAYING	AMOUNT	PERIOD
1.			
2.			

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
Assets that are counted include: cash, checking and savings accounts, recreational vehicles, real estate other than the home or land you live on, a life insurance policy with a cash surrender value, stocks and bonds.

TYPE OF ASSET	HOUSEHOLD MEMBER	AMOUNT	PERIOD	BANK/ DESCRIPTION

CREDIT/RECURRING ACCOUNTS NAME AND ADDRESS OF CREDITOR	WHAT WAS PURCHASED	AMOUNT FINANCED	UNPAID BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				

CHILD SUPPORT EXPENSES HOUSEHOLD MEMBER MAKING PAYMENT	CHILD NAME	AMOUNT	PERIOD
1.			
2.			

Are you seeking financial assistance for treatment related to: ❑ Workplace injury ❑ Accident ❑ Crime ❑ Cancer
If yes, please provide details:

Discrimination is Against the Law

Hospital Sisters Health System (HSHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HSHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HSHS provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

HSHS provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the telephone numbers or TYY numbers listed below.

If you believe that HSHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

System Responsibility Officer and 1557 Coordinator
Hospital Sisters Health System
4936 Laverna Road
Springfield, Illinois 62794
Telephone: 1-217-492-6590
FAX: 1-217-523-0542

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a system responsibility officer and 1557 coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:

Tieng Viet (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:

한국어 **(Korean)**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오.

िहदी (Hindi)
ध्या द: यिद आप िहदी बोलते ह तो आपके िलए मु त म भाषा सेवाएं पल ह। पर कॉल कर।

اُردو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ.

ar (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم (رقم هاتف الصم والبكم:

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.
https://www.illinoisattorneygeneral.gov/about/contacts.html

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer:

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:

Deitsch (Pennsylvania Dutch)
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff:

Français (French)
ATTENTION : Si vous parlez français, des services d'aidelingui

HSHS St. John's Hospital, Springfield, IL
1-217-544-6464; TTY via IL Relay: 1-800-526-0844

HSHS St. Mary's Hospital, Decatur, IL
1-217-464-2966; TTY via IL Relay: 1-800-526-0844

HSHS St. Francis Hospital, Litchfield, IL
1-217-324-2191; TTY via IL Relay: 1-800-526-0844

HSHS Good Shepherd Hospital, Shelbyville, IL1-
217-774-3961

HSHS Holy Family Hospital, Greenville, IL
1-618-664-1230; TTY via IL Relay: 1-800-526-0844

HSHS St. Anthony's Memorial Hospital, Effingham, IL
1-217-342-2121; TTY via IL Relay: 1-800-526-0844

HSHS St. Elizabeth's Hospital, O'Fallon, IL
1-618-234-2120, TTY 1-618-641-5435

HSHS St. Joseph's Hospital, Breese, IL
1-618-526-4511; TTY via IL Relay: 1-800-526-0844

HSHS St. Joseph's Hospital, Highland, IL
1-618-651-2600; TTY via IL Relay: 1-800-526-0844

HSHS Medical Group
1-217-321-9292
Prairie Cardiovascular Consultants
1-217-788-0706