Hospital Sisters
HEALTH SYSTEM

Patient
Name:
Facility:

Account Number	Date of Service

Dear

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help HSHS determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. 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. 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.

Please complete this form and submit it to the hospital in person, by mail (listed below), email (listed below), MyChart (https://www.myhshs.org/myhshs/Authentication/Login?), or fax (513)653-4099 to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care. Electronic signatures are accepted. Note: Once approved, your application is valid for 6 months from the determination date and will retroactively cover 240 days prior to the date of application. Financial assistance is not retroactive to services outside this window.

Eligibility for financial assistance is determined through an income assessment, which follows federal poverty guidelines and considers the exhaustion of other available payment sources. **In certain circumstances, patients may qualify for Presumptive assistance.** These circumstances include homelessness, being deceased with no estate, mental incapacitation without a representative, Medicaid eligibility, or enrollment in state or government assistance programs. This application is designed to help assess your eligibility under the Fair Patient Billing Act (FPBA) and other applicable programs. **Please note that some programs may have a specific application period.**

To determine eligibility, submit the completed application along with at least one form of income verification and proof of assets for each household member. (Upon review, additional clarification may be requested):

- ☐ Employment = paystubs showing gross income for 1 or 12 months prior to the date of application, or a written verification letter from an employer
- ☐ Tax Return, or W-2, or 1099 = Complete most recent tax forms from most recent filing including Schedule C for self-employment
- ☐ Social Security/Pension/Disability = Most recent benefit letter
- ☐ Checking/Savings = 1 month of complete (all pages) bank statement for each account

You can find more information, including our financial assistance policy and a plain language summary located on our website at https://www.hshs.org/about-us/patient-financial-services-1. Applications are available in English and Spanish. If you have any questions, or if you need assistance in another language, please contact Customer Service at (833) 464-1778.

Thank you,
Public Benefits Department

Return Applications to:
Attention: Financial Assistance Program
P.O. Box 13427
Springfield, IL 62791
HSHSCharityservice@Ensemblehp.com

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.
Phone: 1-877-305-5145
Website: https://illinoisattorneygeneral.gov

Hospital Sisters
HEALTH SYSTEM

Financial Assistance Application

Patient (First & Last) Name:		Patient Account Number:
Street Address:		
City:	**State:**	**Zip Code:**
Phone: (_____) _____ -_____		**Last 4 of Social Security Number:**

HOUSEHOLD INFORMATION: Please list everyone who lives in the household, including:
Yourself (if not patient), the patient, spouse (if married), and any biological/legally adopted children under 18 years old.

First and Last Name	Relationship to Patient	Date of Birth	Total Monthly Gross Income Prior to the Date of Service or Application
	Self		

Income includes wages, Social Security, unemployment, child support, and other sources

Please explain why you are applying for assistance, if you have no income, how are you meeting your basic needs? If you have changes in your income in the past 12 months, please explain.

_____

_____

Does anyone in your household have state or federal assistance? If so, you may qualify for Presumptive assistance and are not required to provide expenses. Please provide documentation:

□ SNAP/Food Share □WIC □TANF □HUD □Homeless □Community Clinic (_____)

Did you have health insurance on the date of service? ☐ No ☐ Yes (*Provide copy of card*)

Were you an Illinois resident at the time of service? ☐ No ☐ Yes *(Provide a current ID)*

Was your date of service related to an accident or a crime? ☐ No ☐ Yes*(If yes, please describe)*_____

Does anyone in your household have a checking and/or savings account(s)? ☐ No ☐ Yes (*Total Amount*)_____

Does anyone in your household have any other assets (CD's, Stocks, HSA, property, etc.)? ☐ No ☐ Yes*(Type and Value)*

_____

Please list your monthly expenses (**Optional:** including but not limited to housing, utilities, food, transportation, childcare, medical expense, etc.):_____

For **Income/Assets** listed above, you must provide one of the following proof of income and proof of assets for each member of the household:

☐ Employment = paystubs showing gross income for 1 or 12 months prior to the date of application, or a written verification letter from an employer

☐ Tax Return, or W-2, or 1099 = Complete most recent tax forms from most recent filing including Schedule C for self-employment

☐ Social Security/Pension/Disability = Most recent benefit letter

☐ Checking/Savings = 1 month of complete (all pages) bank statement for each account

By signing this document, 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 may be verified by the hospital, and I authorize the hospital to contact third parties 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 hospital bill.

Patient Signature: _____ **Date:** _____

Public Benefits Dept.
Attention: Financial Assistance Program P.O. Box 13427 Springfield, IL 62791