2200 State Street
Lawrenceville, IL 62439

<u>STATEMENT OF FINANCIAL OBLIGATIONS FOR</u>
<u>Uninsured Patient Discount Program - ILLINOIS RESIDENT</u>

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Lawrence County Memorial Hospital 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.

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/clinic 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.

The hospital will provide a discount to the uninsured patient without any health insurance or coverage for medically necessary services, including comprehensive primary care. To be eligible the patient must be an Illinois resident and the household income must not be more than 300% of the Federal Poverty Level. Failure to provide required documentation within 30 days of the request will result in the discount not being given.

Uninsured Person: ____ Date of Birth: ________________

Address: ____ Phone: _______________________

Spouse: ____ Date of Birth: _________________

Address: ____ Phone: _______________________

Number of Family Members: __________________________________ Ages: _______________________

Residency verification is required. Acceptable documentation may include one of the following:

Valid **Illinois** issued ID	Recent residential utility bill
Current lease agreement	Vehicle registration card
Voter registration card	Mail addressed to the uninsured from a government agency

Statement from a family member of the uninsured who resides at the same address and presents verification of residency

INCOME

Employer: ______________________________ Address: ______________________________

Spouse Employer: ______________________________ Address: ______________________________

Monthly Income:	Wages (Yours)	$__________
	Wages (Spouse)	$__________
	Unemployment	$__________
	Disability	$__________
	Social Security	$__________
	Child Support, alimony or other spouse support	$__________
	Pension	$__________
	Other	$__________
Total Monthly Income:		**$__________**

Note:

In order for the hospital to qualify the patient for the discount acceptable documentation must be provided

Copy of one of the following is required to verify income:

Most recent income tax return

Most recent W-2 form and 1099 form

Two most recent pay stubs

Employer written income verification if paid in cash

Other form of third party income verification deemed acceptable to the hospital

If unemployed, please provide appropriate verification.

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.

Applicant Signature________________________ Co-Applicant Signature________________________

Date____________________________________

Note:

Once the uninsured patient is deemed eligible for the discount, the maximum collectable amount for the 12-month period from the date of service deemed eligible will be 25% of the family's gross annual income.

Please return this form along with residency and income verification to:

Lawrence County Memorial Hospital
Attn: Patient Accounts
2200 State St
Lawrenceville, IL 62439

If you are not an Illinois resident, we have other assistance you may qualify for. Questions about this application should be addressed to Patient Accounts at 618-943-1000.