FAIRFIELD MEMORIAL HOSPITAL
303 NW 11TH STREET
FAIRFIELD, ILLINOIS 62837
618-842-2611

HORIZON HEALTHCARE
213 NW 10TH STREET, STE. A
FAIRFIELD, ILLINOIS 62837
618-842-4617

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME: _____ PHONE #: _____

PATIENT ADDRESS: _____

EMPLOYER: _____

Important: You may be able to receive free or discounted care: Completing this application will help Fairfield 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.

Uninsured patients who demonstrate one of the following Presumptive Eligibility Criteria (homeless, deceased with no estate, mental incapacitation with no one to act on patient=s behalf, Medicaid eligible but not on date of service) are automatically eligible to receive ***free care*** and ***no proof of income will be requested***. We verify eligibility electronically when possible, but may need you to assist us to demonstrate your eligibility.

Please complete this form and submit it to the hospital in person, by 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.

INCOME:

$ _____ Total gross income for the past twelve months for ALL members of the household must be listed**. Proof of income must be returned with this application - Complete Income Tax Form 1040 with schedules, W-2 Form and a current paycheck stub with year to date income.**			
Wages	$_____	Child Support	$_____
Farm or Self-Employment	$_____	Pension/ADC/Welfare	$_____
Public Assistance	$_____	Rental Income	$_____
Social Security	$_____	Insurance Disability	$_____
Unemployment Compensation	$_____	Other	$_____
Worker's Compensation	$_____	Other	$_____
Alimony	$_____	Other	$_____
If unemployed, date last worked _____		☐ No taxes were filed	

HOUSEHOLD SIZE:

NAME	DATE OF BIRTH	RELATIONSHIP	SSN #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT'S NAME: _____

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's Signature: _____ Date of Request _____

Applicant's Signature: _____ Date of Request _____

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☐ Application Approved ☐ Application Denied

_____

(Hospital Representative Signature) Date

Rev. 9.2017