Financial Assistance Program (FAP) Plain Language Summary

Harrisburg Medical Center is committed to serving our community and grants financial assistance, in the form of free or discounted care, to patients who meet the criteria of the Financial Assistance Program. The FAP provides assistance to individuals who are uninsured or under-insured and have medical bills for care billed by Harrisburg Medical Center at the following locations:

- Harrisburg Medical Center, Inc.
- Harrisburg Medical Center Physician billing
    - Certified Registered Nurse Anesthetists
    - EKG &stress tests provided by Dr. Shannon Rider, Loni Banks, FNP & Mary Ozee, FNP
    - Sleep study interpretation provided by Dr. Suhail Istanbouly
    - Pulmonary services provided at HMC by Dr. Chirag Dave
    - Surgical services provided at HMC by Dr. Marie Gorski
- Mulberry Center including Inpatient services provided by Dr. Naeem Qureshi, Kasey Harner, NP, Gabriel Martin, PA-C, Katrina Tripp, PA-C
- Eldorado Primary Care
- HMC Clinic at Harrisburg
- HMC Clinic at Marion

Individuals meeting the Program criteria may be approved for a full or partial reduction of their hospital bill and will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed to third party payors.

Providers delivering care in the hospital which are not covered by the financial assistance policy are cardiologists, hospitalists, emergency department, gastroenterologists, pediatric cardiologists, nephrologists, obstetricians and gynecologists, nephrologist, neurologist/sleep medicine, oncologist/hematologist, ophthalmologists, pathologists, podiatrists, psychiatrists not employed by the hospital, pulmonologists not employed by the hospital, urologists, radiologists, surgeons not employed by the hospital, and family practice physicians not employed by the hospital. To request listing by provider name contact the Financial Counselor at (618)253-7671 ext. 10251, email patientaccounts@harrisburgmc.com or visit our website at www.harrisburgmc.com.

To apply for the Financial Assistance Program or to learn more about the Financial Assistance Program:

- Visit our website at www.harrisburgmc.com
- Email patientaccounts@harrisburgmc.com
- Visit a Financial Counsleor, Monday thru Friday, 8:00 am – 12:00 pm or 12:30 pm- 4:30 pm at
  100 Dr. Warren Tuttle Dr.
  Harrisburg IL 62946
- Call a Financial Counselor at (618)253-7671 ext. 10251

Eff 11/24/2020

Harrisburg Medical Center (618)253-0251
HMC Surgical Services (618)253-0169
HMC Clinic at Harrisburg (618)252-0411
HMC Clinic at Marion (618)997-4332
Eldorado Primary Care (618)273-7723

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Harrisburg Medical Center 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 or clinic staff.

For questions or assistance:

Visit our website at www.harrisburgmc.com
Email patientaccounts@harrisburgmc.com
Call a Financial Counselor at (618)253-7671 ext. 10251
Visit a Financial Counselor Monday thru Friday, 8:00 am – 12:00 or 12:30 - 4:30 pm at
100 Dr. Warren Tuttle Dr.
Harrisburg IL 62946

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 or clinic determine whether you qualify for any public programs.

Please complete this form and submit it and supporting documents listed below to the hospital or clinic in person, by mail, by electronic mail to patientaccounts@harrisburgmc.com, or by fax at (618)253-0475 to apply for free or discounted care prior to care or within 30 days following the date of discharge or receipt of outpatient care.

- ✓ Complete Federal & State Income Tax Return (including all schedules)
- ✓ Proof of Income, Patient(s) & Guarantor (i.e. current pay stubs with year-to-date income, Social Security letter, unemployment received, pension letter, etc.)
- ✓ Proof of Income. If you are self-employed must provide current year-to-date interim Income Statement.
- ✓ No Income Letter, if applicable (Form Attached)

Section 1: PATIENT 1

Full Legal Name	Date of Birth	Social Security Number (not required)

Address (Number and Street, City, State, Zip Code)	Home Phone No	Cell Number

Is the patient an Illinois resident when care was or will be rendered? Yes or No
Is care related to an alleged accident? Yes or No If yes, who is the responsible party:_____
Is care related to an alleged crime? Yes or No If yes, has a claim been filed with Crime Victims? Yes or No

Occupation	Name of Current Employer	Address/Phone Number of Employer

Does the patient have any insurance or third party coverage: Yes or No
Mark all that apply:

Medicare Part A Medicare Part B
Medicaid, list state and name of plan:_____
Veteran's benefits
Health insurance, list name _____
Supplemental plan, list name _____
Other coverage, list name _____

PATIENT 2, if in the same family and the patient is applying for financial assistance.

__ **N/A.** Mark if not applicable because the patient is not applying for financial assistance. Skip to Section 2.

_____ _____ _____
Full Legal Name Date of Birth Social Security Number (not required)

_____ _____ _____
Address (Number and Street, City, State, Zip Code) Home Phone No Cell Number

Is the patient an Illinois resident when care was or will be rendered? Yes or No
Is care related to an alleged accident? Yes or No If yes, who is the responsible party: _____
Is care related to an alleged crime? Yes or No If yes, has a claim been filed with Crime Victims? Yes or No

_____ _____ _____
Occupation Name of Current Employer Address/Phone Number of Employer

Does the patient have any insurance or third-party coverage: Yes or No Mark all that apply:

Medicare Part A Medicare Part B
Medicaid, list state and name of plan _____
Veteran's benefits
Health insurance, list name _____
Supplemental plan, list name _____
Other coverage, list name _____

PATIENT 3, if in the same family and the patient is applying for financial assistance.

__ **N/A.** Mark if not applicable because the patient is not applying for financial assistance. Skip to Section 2.

_____ _____ _____
Full Legal Name Date of Birth Social Security Number (not required)

_____ _____ _____
Address (Number and Street, City, State, Zip Code) Home Phone No Cell Number

Is the patient an Illinois resident when care was or will be rendered? Yes or No
Is care related to an alleged accident? Yes or No If yes, who is the responsible party: _____
Is care related to an alleged crime? Yes or No If yes, has a claim been filed with Crime Victims? Yes or No

_____ _____ _____
Occupation Name of Current Employer Address/Phone Number of Employer

Does the patient have any insurance or third-party coverage: Yes or No Mark all that apply:

Medicare Part A Medicare Part B
Medicaid, list state and name of plan: _____
Veteran's benefits
Health insurance, list name _____
Supplemental plan, list name _____
Other coverage, list name _____

PATIENT 4, if in the same family and the patient is applying for financial assistance.

__ **N/A.** Mark if not applicable because the patient is not applying for financial assistance. Skip to Section 2.

_____ _____ _____
Full Legal Name Date of Birth Social Security Number (not required)

_____ _____ _____
Address (Number and Street, City, State, Zip Code) Home Phone No Cell Number

Is the patient an Illinois resident when care was or will be rendered? Yes or No
Is care related to an alleged accident? Yes or No If yes, who is the responsible party: _____
Is care related to an alleged crime? Yes or No If yes, has a claim been filed with Crime Victims? Yes or No

_____ _____ _____
Occupation Name of Current Employer Address/Phone Number of Employer

Does the patient have any insurance or third-party coverage: Yes or No Mark all that apply:

Medicare Part A Medicare Part B
Medicaid, list state and name of plan: _____
Veteran's benefits
Health insurance, list name _____
Supplemental plan, list name _____
Other coverage, list name _____

If more than 4 patients in the same family are applying for financial assistance add additional pages.

Section 2: GUARANTOR OR RESPONSIBLE PARTY INFORMATION (i.e. Parent, Guardian, etc.)

If the guarantor or responsible party is the same as a patient listed in Section 1 skip this section.

_____ _____ _____
Full Legal Name Date of Birth Social Security Number (not required)

_____ _____ _____
Address (Number and Street, City, State, Zip Code) Home Phone No Cell Number

_____
List relationship to patient(s)

Section 3: HOUSEHOLD INFORMATION

List the number of persons in the patient's family: _____
List the Ages of Dependents (not including self) that guarantor or responsible party claimed on their last tax return.
Ages: _____

Section 4: GROSS INCOME
Total Family Income PER MONTH

$_____	Wages: Patient's Income (GROSS)
How often are you paid:	Weekly Bi-Weekly Bi-Monthly Monthly Other: _____
$_____	Wages: Spouse/Parent/Other Responsible Party Income (GROSS)
How often are you paid:	Weekly Bi-Weekly Bi-Monthly Monthly Other: _____
$_____	Social Security Benefits
$_____	Pension (including VA pension)
$_____	Disability Benefits
$_____	SSI/TANF
$_____	Child Support, Alimony or Other Spousal Support
$_____	Self-Employment or Business Income
$_____	Unemployment Compensation benefits
$_____	Workman's Compensation benefits
$_____	General Assistance
$_____	Other (specify)_____
$_____	TOTAL MONTHLY INCOME

Section 5: SPECIAL SITUATIONS
****** If guarantor or responsible party did not file a tax return please indicate the reason below and the last year filed.

_____
_____
_____
_____
_____

Section 6: MEDICAL INDEBTEDNESS: If you are applying based on medical indebtedness attach list of all medical bills with most recent billing statements.

By signing below, 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.

_____ _____
Signature of Patient/Responsible Party Date

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