☐ Harrisburg Medical Center
100 Dr Warren Tuttle Dr
Harrisburg IL 62946
(618)253-0251
Fax (618)253-0475
Email: HMC_Patient_Accounts@sih.net

☐ HMC Clinic at Marion
3106 Outer Dr
Marion IL 62959
(618)997-4332

☐ Eldorado Primary Care
1007 US Hwy 45 North
Eldorado IL 62930
(618)273-7723

Dear Patient or Guarantor:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help 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.

Harrisburg Medical Center (HMC) 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 Healthcare Assistance Program. The HAP 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.
- Eldorado Primary Care
- 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 anesthesiologists, certified nurse anesthetists, cardiologists, hospitalists, emergency department providers, gastroenterologists, pediatric cardiologists, nephrologists, obstetricians and gynecologists, nephrologist, neurologist/sleep medicine, oncologist/hematologist, ophthalmologists, pathologists, podiatrists, pulmonologists not employed by HMC, urologists, radiologists, surgeons not employed by HMC, and family practice physicians not employed by HMC. To request listing by provider name contact the Financial Counselor at (618)253-7671 ext. 10251, email HMC_Patient_Accounts@sih.net or visit HMC's website at www.harrisburgmc.com.

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 fax (618)253-0475 or by email HMC_Patient_Accounts@sih.net to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care.

Patient or guarantor 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 understand, in order to receive assistance with your hospital bill, you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. All payment sources must be fully exhausted before healthcare assistance will be considered.

Certain circumstances in which a patient may be eligible for presumptive eligibility may not require an application. Please contact a Financial Counselor at the number above to learn more.

Please return the application with the following information:

1. A complete Healthcare Assistance Program application signed and dated.

2. A copy of your last federal tax return filed. If self-employed you must include Schedule C. Please include a copy of all W2's.

3. A copy of your most recent check or check stub for employment, unemployment, Social Security, pension, workmen's compensation (or work comp determination letter) or any other source(s) of income you have received for the past thirteen (13) weeks. We will accept one of the following three documents for proof of wages:

   a. An employee wage form filled out and signed by your employers for each wage earner in the household. (see application for this form).
   b. Copies of check stubs for the last 13 weeks.
   c. A printout of your wages from your employer for the last 13 weeks.
   d. The above wage information must be approved for all family/household members.

4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Link, school lunches, Child Care Resource or Referral Program.

5. You may be asked to apply for assistance from other appropriate sources if it is determined you could qualify for such aid.

If you want to submit an appeal of our decision or request re-consideration it must be in writing. Please include the reason or provide additional information that may be beneficial for our review.

Complaints or concern 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 at www.illinoisattorneygeneral.gov or 1-800-964-3013.

Only one application is required if you have accounts at any or all of the hospital and clinic locations listed above. If you need assistance in completing the application, please contact the Financial Counselor at (618)253-0251. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

Completion of this application does not relieve you of your financial obligation to Harrisburg Medical Center. Harrisburg Medical Center reserves the right to deny any application upon review.

Sincerely,

HMC Financial Counselor

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Healthcare Assistance Application

Name: ____ Date of Birth: __________________

Address: ____ ______________________________
Street Address/PO Box City State Zip Code

Phone Number:_______________________ Social Security Number _____________ (not required)

Family/household information:

1. Number of persons in the patient's family/household: _____________
2. Number of persons who are dependents of the patient: _____________
3. Ages of patient's dependents: _______________________________

Employment and Income Information

1. Enter patient, spouse and/or partners employer information.
2. If patient is a minor, enter the patient's parent's or guardian's employer information.

Patient	Spouse	Partner	Other
Patient's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Spouse's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Partner's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Other Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?
Patient's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Spouse's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Partner's Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?	Other Employer Name: ___________________ Address: ___________________ City, State, Zip ___________________ Salary: Gross Amount ___________________ Paid how often?

Other Income

Other Income	Patient's Monthly Income	Spouse/Partner/Other Dependent's Monthly Income
Wages	$	$
Self -Employment	$	$
Unemployment Compensation	$	$
Social Security	$	$
Social Security Disability	$	$
Veteran's Pension/Disability	$	$
Workers' Compensation	$	$
Temporary Assistance for Needy Families	$	$
Retirement Income	$	$
Child Support, Alimony or Other Spousal Support	$	$
Other Income	$	$

Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

Assets

****Assets are not required for National Health Services Corps (NHSC) Locations at HMC Clinic at Marion or Eldorado Primary Care**.

Real Estate: Own _____ Rent ______		Bank: Checking	$
Market Value	$	Savings	$
Amount Owed:	$		
	$	Mutual Funds:	$
Auto/Truck/Type:		Stocks, CD's:	$
Market Value:	$	Rental Property Owned:	$
Motorcycles, Boats, Campers, Other Vehicles:		Other:	$
Market Value	$		$
			$
			$

Monthly Expenses

Rent or House Payments:	$	Other:	$
Utilities	$		$
	$		$
	$		$
	$		$
Child Care:	$		$
Food and Supplies:	$		$
Auto Payments:	$		$
Transportation	$		$
Credit Cards:	$		$
Property Tax: (Annual) :	$		$
		Total Monthly Expenses	

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.

Y ☐ N ☐ Was the patient an Illinois resident or temporary resident when care rendered?

*If temporary resident, please provide copy of temporary visitor's driver's license

Y ☐ N ☐ Was the patient involved in an alleged accident?

Y ☐ N ☐ Was the patient a victim of an alleged crime?

Y ☐ N ☐ Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?

Y ☐ N ☐ Does applicant(s) have insurance benefits OR Medishare/Ministry funded plan?

OPTIONAL DEMOGRAPHIC INFORMATION: (circle best option)

***Response or nonresponse will not have any impact on the outcome of this application**

Race
American Indian or Alaska Native
Asian
Asian Indian
Black or African American
Chinese
Native Hawaiian or Other Pacific Islander
Other Race
White

Ethnicity
Hispanic or Latino
Not Hispanic, Latino/a, or Spanish Origin

Sex
Male
Female
Male transitioning to Female
Female transitioning to Male

Preferred Language: ____

Complaints or concern 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 at www.illinoisattorneygeneral.gov or 1-800-964-3013.

Date: ______________________________ Signed: ____
Patient/Guarantor/Applicant

Date: ______________________________ Signed: ____
Patient/Guarantor/Applicant

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

   ____
   ____
   ____

2. If your tax return is not included, please explain why.

   ____
   ____
   ____

3. If you have no income how do you support yourself?

   ____
   ____
   ____

4. If you are receiving financial support from anyone, include a written statement how they are helping you.

   ____
   ____
   ____

5. Other:

   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

Employee Wage Form

(To Be Completed and Signed by Employer)

Employee Name: ______________________________

Employee Social Security Number: ___________________________________ (not required)

Employer Name: ______________________________________Tele: ____________Ext. _________

Address: ____

City State Zip Code

Wages For The Last 13 Weeks

Week	Pay Period Ending	Gross Wages
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____________(yes/no); If no, when was the last day worked? ______________
2. If the employee is not currently working, will the employee be returning to work? __________ (yes/no) Expected return date ________________
3. When did employment begin: _____________________ End: ____________________

I certify the wage information regarding the person named above is true and accurate.

Date: ____________________ Signed: ____

Signature of Employer or Employer's Representative