Hillsboro Area Hospital

SPECIAL FINANCIAL CONSIDERATIONS APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Hillsboro Area Hospital determinie 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 if you qualify for any public programs.

Please complete this for 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.

Patient/Family Information

Patient Name: _____

Address: _____ Telephone: _____
_____

Employer: _____ Phone: _____
Address_____
_____

Spouse Employer: _____ Phone: _____
Address_____
_____

Number of Dependents of Patient: _____

Name: Age:
_____
_____
_____
_____

Income Sources (Before Taxes)

Verification Required (Last Year's Taxes, Check Stubs, Social Security, Etc.)

Gross Wages-Resp. Party: _____ Gross Wages Spouse: _____
Self-Employment:_____ Public Assist. /Welfare:_____
Alimony/Child Support_____ Work comp/Unemployment: _____
Dividends/Interest: _____ Pensions/SSI/Disability _____
Estates/Trusts: _____ Rents/Royalties: _____
Other: _____ Total Gross Income:_____

Assets

Cash Amount: $ _____ Stocks/Bonds/Investments: _____
Bank Name: _____ _____
Savings$_____ Checking$_____
Vehicles/Year/Make:_____ Rental Properties_____
Value:$_____ Total Assets:_____

I hereby state that the information given is true and complete 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 Date

Additional information is needed to complete your Special Financial Consideration Application.

Please send all that apply to you and your family.

1. Proof of income for the last 3 months for you and your spouse. Example:
   A: copies of pay stubs or a statement signed by your employer
   B: self-employment records
   C: copy of social security or disability income
   D: copy of pension or retirement income
   E: copy of unemployment income
   F: copy of worker's compensation income
   G: copy of child support or alimony income
   H: copy of temporary assistance for needy families (TANF)
   I: copy of any other income you received

2. A copy of your last year's income tax return or W-2.
3. If you are not employed, please explain how you are obtaining housing and food.

After receiving the completed, signed application and the additional required information you will be given a decision in writing within 5 working days.

Please have the application returned within 2 weeks to the Hospital Business Office.

Please contact me if you have any questions.

Kelly Everett, Financial Counselor 217-532-4194

Revised 08/15/13