



Hillsboro Area Hospital

SPECIAL FINANCIAL CONSIDERATION APPLICATION

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

You will received a separate billing from our physicians, including the Radiologist, other consultants as ordered by your physician, and for anesthesia services. These are not covered under our Financial Assistance Program.

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 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.

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: _____
Self-Employment: _____
Alimony/Child Support _____
Dividends/Interest: _____
Estates/Trusts: _____
Other: _____

Gross Wages Spouse: _____
Public Assist. /Welfare: _____
Work comp/Unemployment: _____
Pensions/SSI/Disability _____
Rents/Royalties: _____
Total Gross Income: _____

Assets

Cash Amount: \$ _____
Bank Name: _____
Savings\$ _____
Vehicles/Year/Make: _____
Value:\$ _____

Stocks/Bonds/Investments: _____
Checking\$ _____
Rental Properties _____
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 business days.

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

Please contact me if you have any questions.

Susan Rikli, Financial Counselor 217-532-4204