PINCKNEYVILLE COMMUNITY HOSPITAL
PATIENT FINANCIAL ASSISTANCE APPLICATION

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

Please complete this application and submit within 60 days following date of discharge or receipt of outpatient care to apply for free or discounted care. Completed applications can be submitted as follows:

- In person to the Patient Financial Counselor at Pinckneyville Community Hospital
- By email to pchfinancialassistance@pvillehosp.org
- By fax to 618-357-6740 Attn: Patient Financial Counselor
- By mail to: Pinckneyville Community Hospital, Attn: Patient Financial Counselor, PO Box 437, Pinckneyville, IL 62274

Documentation to be provided along with the completed application:

- Proof of income from one source: last two pay stubs, most recent W2(s), or most recent tax return.
- Proof of household size through copy of most recent tax return.
- Most recent two statements from any bank, savings or other financial accounts.*

*Asset information is not used for determining eligibility for financial assistance (sliding fee discount). Asset information is only used for calculating medically indigent status. Financial Assistance (sliding fee discount) eligibility is determined based on income and household size only.

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 NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____ EMAIL: _____

ILLINOIS RESIDENT WHEN CARE WAS RENDERED? YES ___ NO ___
SERVICES RELATED TO AN ALLEGED ACCIDENT? YES ___ NO ___
VICTIM OF AN ALLEGED CRIME? YES ___ NO ___
OPTIONAL: In accordance with the Illinois Hospital Uninsured Patient Discount Act, we are required to ask the following. Completion is optional. Responses or nonresponses will not have any impact on the outcome of the application.

RACE: __ White __Black or African American __Asian American Indian or Alaska Native __Native Hawaiian or Other Pacific Islander
ETHNICITY: ___Non-Hispanic ___ Hispanic
Gender at birth: ___ Male ___ Female Preferred Gender: ___ Male ___ Female
PREFERRED LANGUAGE: _____

GUARANTOR NAME: _____

GUARANTOR ADDRESS: _____

GUARANTOR PHONE NUMBER: _____

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PATIENT FINANCIAL ASSISTANCE APPLICATION

HOUSEHOLD SIZE

Number of persons in the patient's family/household _____ Number of Dependents _____

Ages of Dependents covered by this application:

Age	Age	Age	Age	Age	Age	Age	Age

HOUSEHOLD INCOME CALCULATION

Are you currently employed? YES ___ NO ___

If yes, please provide name, address and telephone number of all employers:

Name	Address	Phone
Name	Address	Phone

Please provide name, address and telephone number of all employers of the guarantor:

Name	Address	Phone
Name	Address	Phone

If divorced or separated or a party to a dissolution proceeding, is your former spouse or partner financially responsible for you or your dependent's medical care per the dissolution of separation agreement? YES ___ NO ___

Gross monthly family income, including that of guarantor, from all sources such as: Wages, Self-employment, Unemployment Compensation, Social Security, Social Security Disability, Veterans' Pension, Veterans' Disability, Private Disability, Workers Compensation, Temporary Assistance for Needy Families (TANF), Retirement income, Child support, alimony or other spousal support, and other income. Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation shall be provided by the patient.

Wage Type:	Wage Type:	Wage Type:
Amount:	Amount:	Amount:
Frequency of Payment: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annual ☐ Other _____	Frequency of Payment: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annual ☐ Other _____	Frequency of Payment: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annual ☐ Other _____

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INSURANCE COVERAGE
Check all that apply:

Patient:	Spouse/Guarantor:	Dependents:
☐ Health Insurance	☐ Health Insurance	☐ Health Insurance
☐ Medicare	☐ Medicare	☐ Medicare
☐ Medicare Part D	☐ Medicare Part D	☐ Medicare Part D
☐ Medicare Supplement	☐ Medicare Supplement	☐ Medicare Supplement
☐ Medicaid	☐ Medicaid	☐ Medicaid
☐ Veterans' benefits	☐ Veterans' benefits	☐ Veterans' benefits
☐ Settlement received to cover medical expenses	☐ Settlement received to cover medical expenses	☐ Settlement received to cover medical expenses

Medically Indigent Status Determination Information:
MEDICAL EXPENSES $ _____ (attach current bills showing portion of balance you owe)

ASSET INFORMATION* Do you have any other assets? ☐ no ☐ yes (include all values below and provide copies of two most recent statements)

*Asset information is not used for determining eligibility for financial assistance (sliding fee discount). Asset information is only used for calculating medically indigent status. Financial Assistance (sliding fee discount) eligibility is determined based on income and household size only.

Checking $_____ Savings $_____

Stocks $_____ Certificates of Deposit $_____

Mutual Funds $_____ Health Savings/Flexible Spending Account $_____

Real Estate other than your primary residence $_____
Automobiles, Motorcycles, Boats, Campers, Recreational & other vehicles:

Description _____ $_____ Description _____ $_____

Description _____ $_____ Description _____ $_____

Description _____ $_____ Description _____ $_____

Patient/Guarantor Certification:
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.

If you have questions or concerns, you may contact Pinckneyville Community Hospital's Financial Counselor at 618-357-5906. Complaints or concerns 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:
Website: https://www.illinoisattorneygeneral.gov/consumers/healthcare.html
Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)

_____ _____
Patient or Applicant Signature Date

PATIENT FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

HOUSEHOLD INFORMATION:
Number of persons in the patient's family/household shall exclude any non-minor children, living at home but not claimed on the parents' tax return, who are required to apply separately for financial need. Number of dependents includes those that are claimed on your tax return. You will be required to submit a copy of your most recent tax return to support the number of claimed household dependents. A non-minor child still living in the parent's household, and not claimed on the parent's tax return, shall apply for financial need separately based on his/her own income and not that of the parents. If the non-minor child is claimed on the parent's tax return, then the parents' income should be factored in to the household income for financial need determination.

MONTHLY EXPENSES:
Since monthly expenses are not factored in to Pinckneyville Community Hospital's determination of financial need eligibility, the patient is not required to submit other monthly expense data as part of this application process unless it becomes necessary to help validate the applicant's income. The patient is required to submit outstanding current medical expenses in order to aid in the determination of medically indigent status. If you are receiving financial support from anyone to help with your expenses, please provide a comment regarding who and how they are supporting you.

PUBLIC AID (MEDICAID) ASSISTANCE:
Applicants who are determined to be potentially eligible for Medicaid coverage are required to apply for public aid assistance to determine eligibility under the State Medicaid system prior to determining eligibility for the Uninsured Patient Discount and Financial Need Programs. Additional information, including names of dependents, may be necessary in order to assist in determining your Medicaid eligibility and completing a Medicaid application. If you need assistance obtaining and completing an application, the Patient Financial Services (618-357-5906) and Social Service (618-357-5904) staff at Pinckneyville Community Hospital can assist you. Medicaid co-pays are still collectible and payable regardless of financial need qualification.
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NDEPENDENT PHYSICIAN FEES ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE:
Independent physicians providing services at Pinckneyville Community Hospital, including but not limited to, some surgeons, radiologists, pathologists, and specialty clinic physicians, who bill for their services separately. This Hospital Financial Assistance application does not cover nor apply to fees charged by those independent physicians.

FAMILY MEDICAL CENTER:
The Family Medical Center is a hospital based rural health clinic operated under Pinckneyville Community Hospital. Eligibility for financial need assistance as determined through this Patient Financial Assistance application will apply to services billed through the Family Medical Center.

ATTACHMENTS:
If you do not have access to a copier, feel free to bring in your original supporting documentation when returning this completed application and we will be happy to make the necessary copies for you.

NOTIFICATION AND APPROVALS:
Notification of approval or request for additional information will be provided to you within approximately 2 weeks of returning the application with all completed documentation. Any approved financial need expires six (6) months from the approval date. Upon expiration of the approval, applicant will be asked to complete a new application form to update on the current financial status and any changes thereof.

PINCKNEYVILLE COMMUNITY HOSPITAL
PATIENT FINANCIAL ASSISTANCE APPLICATION

FOR HOSPITAL OFFICE USE ONLY:

Date of last applicable date of service for which this application applies: _____

Date application provided: _____

Patient asked to return completed form & documentation by (60 days from date of service): _____

Date received by hospital: _____ Complete? ___ Yes ___ No

Approval date: _____ Valid through: _____

Notes/comments related to the application process:

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Patient Financial Counselor Signature Date