Harrisburg Medical Center
100 Dr Warren Tuttle Dr
Harrisburg IL 62946
(618) 253-0251
Fax (618) 351-6540

SIH Medical Group
1239 East Main Street
Carbondale IL 62901
(618) 457-5200
Ext 67575
Fax (618) 351-6540

Herrin Hospital
201 S. 14th Street
Herrin IL 62948
(618) 942-2171
Ext 36458
Fax (618) 351-6540

Memorial Hospital of Carbondale
405 W Jackson
Carbondale IL 62902
(618) 549-0721
Ext 64572
Fax (618) 351-6540

St Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro, IL 62966
(618) 684-3156
Ext 55331
Fax (618) 351-6540

Dear Patient/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.

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 logging on to MyChart, or by fax to apply for free or discounted care within 90 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.

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 payors 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/consumers/hcform.pdf or 1-877-305-5145.

SIH now offers convenient electronic option for completing healthcare assistance applications by logging onto MyChart. Visit www.mychart.sih.net 24/7 for complete instructions. You may also mail the completed application to the address listed for the facility where you incurred charges.

Only one application is required if you have accounts at any or all of the hospitals listed above. If you need assistance in completing the application, please contact the Financial Counselor at the appropriate facility. 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 Southern Illinois Healthcare. Southern Illinois Healthcare reserves the right to deny any application upon review.

Sincerely,

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's, patient's spouse or partner's 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 _____	Spouse's Employer Name: Address: City, State, Zip Salary :Gross Amount	Partner's Employer Name: Address: City, State, Zip Salary :Gross Amount	Other Employer Name: Address: City, State, Zip Salary :Gross Amount
Patient's Employer Name: Address: City, State, Zip Salary :Gross Amount _____	Spouse's Employer Name: Address: City, State, Zip Salary :Gross Amount	Partner's Employer Name: Address: City, State, Zip Salary :Gross Amount	Other Employer Name: Address: City, State, Zip Salary :Gross Amount

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

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	$		$
			$
			$

*Assets are not required for National Health Services Corps (NHSC) Location at SIH Primary Care Harrisburg, Eldorado Primary Care, HMC Marion Clinic, Logan Primary Care-West Frankfort, Benton Community Healthcare, Logan Primary Care-Herrin, Center for Medical Arts, Anna Primary Care, Medical Arts Clinic-Murphysboro, West Frankfort Family Medicine

Monthly Expenses

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

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 drivers 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 any 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/consumers/hcform.pdf or 1-877-305-5145.

Date: _____ Signed: _____

Patient/Applicant

Date: _____ Signed: _____

Patient/Applicant

Updated 09.30.24

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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

System Office
1239 E Main St
Carbondale IL 62901

618.457.5200
Fax 618.351.6540

LETTER OF SUPPORT

Date:_____ Applicant/Patient Name:_____
Accounts:_____

To Whom It May Concern:
I am currently providing the following support to the applicant named above

____Applicant receives $_____ each month from me.
____I **do not** provide any monetary assistance to the applicant. I only assist the applicant with Rent, utilities, food etc.
____I claim the applicant on my Federal and State Income tax return.
____I **do not** claim the applicant on my Federal and State Income tax return.

To the best of my knowledge, this person **does not** receive assistance from any other source.
The arrangement began on _____ and will continue until _____, unless the patient obtains employment or makes other living arrangements.

_____ _____
Signature of Party Providing Financial Support Date

_____ _____
Relationship to applicant Telephone Number