Pana Community Hospital

Mail to: Pana Community Hospital
Patient Financial Services Department
101 E Ninth Street
Pana, IL 62557
Fax to: 217-562-6271

FINANCIAL ASSISTANCE - UNINSURED/UNDERINSURED DISCOUNT APPLICATION

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Pana 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.

It is the policy of Pana Community Hospital to provide Financial Assistance to patients in need. Pana Community Hospital will extend medically necessary services free-of-charge, or at a reduced amount, to an individual who is eligible under certain criteria. Applications must be received within 12 months of the date of service.

This application will be used to determine eligibility for both the Financial Assistance 100% discount and the Uninsured/Underinsured 50% discount policies.

Presumptive Eligibility - Patients or their families who demonstrate one of the criteria listed below are automatically eligble to receive free care with the required documentation. Presumptive Eligibility can be demonstrated by one or more of the following criteria: enrollment in certain federal or state programs (See list of programs below), homelessness, mental incapacitation with no one to act of patient's behalf, recent personal bankruptcy, deceased with no estate, incarceration in a penal institution, and affiliation with a religious order and vow of poverty.

List of Federal and State Programs that demonstrate Presumptive Eligibility upon proof of enrollment: WIC (Women, Infants and Children Nutrition Program), SNAP (Supplemental Nutrition and Assistance Program), Illinois Free Breakfast/Lunch, LIHEAP (Low Income Home Energy Assistance Program), a community-based medical assistance program with low-income criteria, grant recipient for assistance for medical services, Medicaid eligibility, TANF (Temporary Assistance for Needy Families), and the Illinois Housing Development Authority's Rental Housing Support Program.

Family's Gross Income - Financial Assistance and Uninsured/Underinsured discount decisions based on the family's "gross income," utilize the gross earnings reportable to the federal government. Patients whose family's gross income does not exceed 2 times the Federal Poverty Level ("FPL") may qualify for the Financial Assistance 100 % discount. (Patients whose family's gross income does not exceed 3 times the Federal Poverty Level ("FPL") may qualify for the Uninsured/Underinsured 50% discount. The FPL varies with the size of the family and is updated annually.

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, or by fax to apply for free or discounted care within 12 months following the date of discharge or receipt of outpatient care.

If you need help to complete this form please ask to speak with our Patient Financial Services Department at 217-562-2131.

Patients may not receive Financial Assistance if they potentially could have qualified for programs, such as Medicaid, but choose not to apply.

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 _____ **Birth Date** _____

Address _____ City/State/Zip _____

Home phone _____ Cell phone _____ Soc Sec # _____

Are you/were you an Illinois resident at the time the services were rendered? YES NO

Were the services rendered as a result of an alleged accident? YES NO

Describe the accident:

Were the services rendered as a result of an alleged crime? YES NO

Describe the crime:

GUARANTOR / (Parent if Minor) Name _____ **Birth Date** _____

Address _____ City/State/Zip _____

Home phone _____ Cell phone _____ Soc Sec # _____

PRESUMPTIVE ELIGIBILITY: Patients or their families who demonstrate one of the criteria listed below are eligible to receive free care. Proof of enrollment and proof of income are required to determine eligibility.

Check as many as apply:

- ☐ WIC
- ☐ SNAP
- ☐ ILLINOIS FREE LUNCH/BREAKFAST
- ☐ INCARCERATED
- ☐ HOMELESSNESS
- ☐ DECEASED WITH NO ESTATE
- ☐ LIHEAP - Low Income Home Engergy Assistance Program
- ☐ COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAM
- ☐ GRANT ASSISTANCE FOR MEDICAL SERVICES
- ☐ TANF: Temporary Assistance for Needy Families
- ☐ PERSONAL BANKRUPTCY
- ☐ AFFILIATION WITH A RELIGIOUS ORDER AND VOW OF POVERTY
- ☐ MEDICAID ELIGIBILITY WITHOUT SPENDDOWN (BUT NOT ON THE DATE OF SERVICE OR FOR NON-COVERED SERVICE)
- ☐ ILLINOIS HOUSING DEVELOPMENT AUTHORITY'S RENTAL HOUSING SUPPORT PROGRAM
- ☐ MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF

We verify electronically with the state system when possible, and appreciate your efforts to assist us in verification by providing: Award letter, statement from Grant Agency, rent receipt in the case of state or federally subsidized housing program, or any other documentation which shows you meet one of the presumptive eligibility criteria

IF YOU DEMONSTRATE PRESUMPTIVE ELIGIBILITY, YOU DO NOT NEED TO SUPPLY HOUSEHOLD EXPENSE INFORMATION. YOU STILL NEED TO COMPLETE THE INCOME AND ASSET INFORMATION AND SIGN THE APPLICANT CERTIFICATION.

MONTHLY HOUSEHOLD INCOME

TYPE	AMOUNT

EMPLOYMENT INCOME (GROSS)	$
EMPLOYMENT INCOME FOR SPOUSE (GROSS)	$
PENSION/RETIREMENT	$
UNEMPLOYMENT	$
DISABILITY	$
CHILD SUPPORT	$
ALIMONY	$
OTHER (PLEASE LIST SOURCE)	$
	$
TOTAL	$

PROOF OF INCOME: Please provide one or more of the following for each employed family member.

1. A copy of most recent tax return
2. A copy of most recent w-2 and 1099 forms
3. A copy of most recent pay stub
4. A statement from your employer if paid in cash
5. Any other verification from a third party about your income

If you cannot provide any documentation relating to your income, fill out the statement below:

I, _____(name), certify that I have no documents that prove my family's monthly income of $_____.

_____

Signature

HOUSEHOLD ASSETS

TYPE	AMOUNT
CHECKING ACCOUNT BALANCE	$
SAVING ACCOUNT BALANCE	$
STOCKS	$
CERTIFICATS OF DEPOSIT	$
MUTUAL FUNDS	$
AUTOMOBILES	$
OTHER VEHICLES	$
REAL PROPERTY	$
HEALTH SAVINGS/FLEXIBLE SPENDING ACCOUNT	$
TOTAL	$

MONTHLY HOUSEHOLD EXPENSES

TYPE	AMOUNT
HOUSING	$
UTILITIES	$
FOOD	$
TRANSPORTATION	$
CHILD CARE	$
LOANS	$
MEDICAL EXPENSES	$
	$
	$
TOTAL	$

DEPENDENT HOUSEHOLD MEMBERS

NAME	AGE	RELATIONSHIP

OTHER INFORMATION

If you have additional documents that may help make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: most recent tax return, phone bills, electricity bills, medical bills, bank or checking statements, charity care acceptance letters from other facilities, etc. . . .)

APPLICANT 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.

APPLICANT SIGNATURE DATE

FOR PCH USE
APPLICATION RECEIVED

BY DATE

PCH 2016