101 East Ninth Street
Pana, IL 62557
(217) 562-2131
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PRESUMPTIVE ELIGIBILITY SCREENING QUESTIONNAIRE

Patient Name______________________________Date of Birth____________________

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 annual household income will be required to verify eligibility.

Are you enrolled in any of the following programs? ☐ YES ☐ NO

Check as many as apply:

- ☐ WIC – Women, Infants and Children Nutrition Program
- ☐ SNAP – Supplemental Nutrition Assistance Program
- ☐ Illinois Free Lunch and Breakfast Program
- ☐ Illinois Housing Development Authority's Rental Housing Support Program
- ☐ LIHEAP - Low Income Home Energy Assistance Program
- ☐ Community-Based Medical Assistance Program
- ☐ Grant Assistance for Medical Services
- ☐ TANF: Temporary Assistance for Needy Families
- ☐ Homeless
- ☐ Recent 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.
- ☐ Deceased, no estate funds available
- ☐ Incarcerated
- ☐ Mental Incapacitation with No One to Act On Patient's Behalf

____ ____________________
Signature of Patient or Guarantor Date

Please return this form with proof of eligibility and proof of household income to the Patient Accounts Department for Presumptive Financial Assistance consideration.