Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: This application will help FHN & FHN Memorial Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form within 240 days following the first billing statement. Submit it to FHN in person, by mail, by electronic mail, or by fax to:

FHN Financial Assistance
1045 W. Stephenson St.
PO Box 268
Freeport, IL 61032
Fax 815-599-7907

Please call our Business Office at 815-599-7950 or 877-720-1555 if you have any questions

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED HOSPITAL 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 FHN determine whether you qualify for any public programs.

Please complete this form and submit all required documentation listed below within 240 days following the first billing statement
and submit to FHN.

Proof of Income for Illinois Uninsured Hospital Discount only, provide at least one of the following:

- Most recent Tax Return
- Most recent W-2s or 1099s
- Two (2) most recent payroll stubs
- Written income verification from an employer, if paid in cash
- One (1) other reasonable form of income verification acceptable to FHN

Proof of Income for all other Financial Assistance programs, provide the following if applicable:

- Most recent Fed Tax Return with all schedules, W-2s, 1099s, etc.
- Two (2) most recent payroll stubs
- Written income verification from an employer, if paid in cash
- Social Security benefits letter(s)
- Most recent bank statement(s)
- Written documentation of any other source of income including but not limited to: Pension, Unemployment, Alimony,
  Child Support, VA benefits, Trust income, Severance pay, etc.

Proof of Residency, provide at least one of the following:

- Valid Driver's License or State ID
- Recent utility bill
- Vehicle or Voter Registration Card
- Lease Agreement or a statement from a Family Member at the same address with acceptable proof of residency

Other Documentation, provide the following if applicable:

- If recently divorced, a copy of divorce decree
- Declination or denial of insurance coverage

Explanation of any missing documentation and extenuating circumstances:

_____

_____

_____

FHN FINANCIAL ASSISTANCE APPLICATION

SECTION 1 - PATIENT (APPLICANT) INFORMATION

Name	Date of Birth	Address - street, city, state, zip.	
SSN	Home Phone	Cell Phone	Email Address
Employer Name	Employer Phone	Employer Address	

SECTION 2 - SPOUSE or PARTNER or GUARANTOR (Please indicate relationship to the patient: _____)

Name		Address - street, city, state, zip.
Home Phone		Cell Phone
Employer Name	Employer Phone	Employer Address

SECTION 3 - HEALTH INSURANCE ELIGIBILITY

SECTION 4 - HOSPITAL PRESUMPTIVE CRITERIA

When FHN provided care was the patient:		Do you have Health Insurance?	Y/N	Insurance Carrier:	Effective Date:	Is the patient homeless?	Y/N					
An Illinois resident?	Y/N	Do you have secondary Ins?	Y/N	Insurance Carrier:	Effective Date:	Is the patient eligible for Medicaid?	Y/N					
Involved in an accident?	Y/N	Have you applied for insurance?	Y/N	Insurance applied for:	Application Date:	Is the patient mentally incapacitated with no one to act on their behalf?	Y/N					
The victim of an alleged crime?	Y/N	Is another person responsible for the patient's medical care as part of a legal dissolution or separation agreement?			Y/N	Is the patient deceased with no estate?	Y/N					

SECTION 5 - FAMILY & HOUSEHOLD INFORMATION

Number of people living in the home:		Number of legal dependents:		Age of legal dependents:								

SECTION 6 - IF YOU ARE UNINSURED AND ANSWERED YES TO ANY PART OF SECTION 4, THIS SECTION IS NOT REQUIRED.

SECTION 6A - MONTHLY GROSS INCOME			SECTION 6B - ASSETS			SECTION 6C - MONTHLY EXPENSE	
	Patient/Applicant	Spouse/Partner/ Guarantor		Description	Value	If you are uninsured and your monthly income is less than $2,000 this section is not required.	
Wages:	$	$	Checking Acct(s):	Bank/Institution	$	Housing:	$
Self Employment:	$	$	Saving Acct(s):	Bank/Institution	$	Utilities:	$
Social Security:	$	$	CD(s):	Bank/Institution	$	Food:	$
Pension or Retirement:	$	$	Investments:	Bank/Institution	$	Transportation:	$
Disability:	$	$	Health Savings or Flex Spend Acct(s)	Bank/Institution	$	Medical Expenses:	$
Unemployment:	$	$	Auto:	Yr. Make & Model	$	Child Care:	$
Workers' Compensation:	$	$	Auto:	Yr. Make & Model	$	Loans:	$
Temp Assistance:	$	$	Other vehicles:	Yr. Type & Model	$	Loans:	$
Child Support:	$	$	Real Estate:	Address	$	Mortgage:	$
Alimony or Spousal Support:	$	$	Real Estate:	Address	$	Mortgage:	$
Other Income:	$	$		Describe	$	Other Expense:	$
Total Monthly Income:	$	$	Total Asset Value:		$	Total Monthly Expense:	$

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 medical bill(s). I understand that the information provided may be verified by FHN and I authorize FHN 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 medical bill(s).

Print or Type Patient/Applicant Name

Print or Type Spouse/Partner/Guarantor

Signature of Patient/Applicant Date

Signature of Spouse/Partner Guarantor Date