Fayette County Hospital & Long Term Care
Professional Care with a Personal Touch

FINANCIAL ASSISTANCE PROGRAM

At Fayette County Hospital, we are concerned about our patients and their families. We understand that healthcare expenses are often unexpected, and paying for services can be overwhelming. This is especially true if you do not have health insurance.

Here, we offer the Financial Assistance Program to all patients who show financial need. Fayette County Hospital has designated funds to aid patients who are unable to pay their obligation in full. Eligibility requirements have been set for those who request assistance. The guidelines are not meant to discourage anyone from seeking treatment. But are designed to ensure the hospital's resources are used for the people who need them most and who are the least able to pay.

The financial information shared in this application will not be shared with anyone outside the hospital without your written authorization.

Applying for Financial Assistance

We want to assist you in finding the best possible solution for you and your family. Before applying for financial assistance, a Patient Account representative will first help you explore all possible options for financial assistance, including private insurance and public aid, where appropriate.

Patients must then request a Financial Assistance Application. Along with the form, you must also provide copies the following financial information:

- **You must first apply for Illinois Public Aid**
- Your most recent federal and state income tax returns
- Your payment stubs from the past three months, or a written statement from your employer verifying your earnings for the past three months
- Your checking and savings account statements from the past three months
- Your monthly social security benefit statement and/or other monthly retirement statements.
- Unemployment/workers compensation check stubs
- Alimony/child support statements
- If you are currently unemployed and you and your family are without income, provide a letter from any person(s) providing you with support for your day-to-day expenses.

Note: Please do not submit original documents; they will not be returned.

Your Patient Accounts Representative can help you complete this form.

Eligibility Guidelines

Income guidelines for eligibility are adjusted annually based on the Federal Poverty Guidelines established by the United State Department of Health and Human Services and published periodically in the Federal Register.

These guidelines are subject to change without notice.

Your Financial Assistance amount will be based on your current account balance. You must contact our Business Office to include any new services and to update your Financial Assistance Application.

If you have any questions or concerns about your billing statement, or you require financial assistance, please contact our Business Office Patient Account Representative at 618-283-5443 Mon-Friday 8am-4pm.

Reviewed 2/15/12

Fayette County Hospital
650 West Taylor Street
Vandalia, Illinois 62471

FINANCIAL ASSISTANCE APPLICATION

Fayette County Hospital offers financial assistance to patients in need. Guidelines have been established to ensure the Hospital's limited resources are used to treat patients who are truly unable to pay and are not consumed by patients unwilling to pay or who have alternate pay sources.

CONFIDENTIAL FINANCIAL STATEMENT

Please complete this form, sign and date. Then return to Fayette County Hospital, Financial Assistance, Business Office, 650 West Taylor St, Vandalia, IL 62471

Patient's Name	_____	Social Security Number	_____
Address	_____	Date of Birth	_____
City, State, Zip	_____	Phone Number	_____
Guarantor's Name (Person responsible for bill, if other than patient)	_____	Social Security Number	_____
Address	_____	Phone Number	_____
City, State, Zip	_____	Alternate Phone Number (Cell, Work, etc)	_____

Marital Status Single Married Separated Divorced Widow(er) Other
Please circle - if other, please explain

Number of people in household ☐
Include ALL individuals living in a single resident
Students at college or prep school should be included if household provides support

DEPENDENTS - Name	**Relationship**	**Date of Birth**

For additional dependents, please attach on a separate sheet of paper

Principal Residence Own Rent Other
If Rent: Name of Landlord _____ Rent Amount
Address _____ $ ☐
City, State Zip _____
If other, please explain Example, live with parents, friend, in college, etc

INCOME - Include all household members that are or will be listed on your tax return
Do not include income for minors

Wages - Current year W-2 and three check stubs/pay vouchers required

Name _____ Indicate how paid and gross income
Employer _____ Hourly Weekly Monthly Annual
Address _____ Other - Please explain
City, State Zip _____ $
Employment Dates _____ to _____
(Month/Year) (Month/Year)

Name _____ Indicate how paid and gross income
Employer _____ Hourly Weekly Monthly Annual
Address _____ Other - Please explain
City, State Zip _____ $
Employment Dates _____ to _____
(Month/Year) (Month/Year)

If multiple employers during year, list employers and wages on separate sheet of paper

INCOME SOURCE

Farm or Self-Employment $ _____
--Include applicable tax schedules

Public Assistance $ _____
--Includes food stamps, circuit breaker, etc.

Unemployment Compensation $ _____
--Indicate length of time, expected return _____
expectations of future employment _____

Workers Compensation $ _____
--Indicate length of time, expected return date _____
expectations of future employment _____

Housing Allowance $ _____
--Rent-free housing provided by employer or organization

Other Allowances $ _____
--Vehicle, utilities, food, etc. Provided by employer or organization

Child Support $ _____

Alimony $ _____

Military Family Allotment $ _____

Pensions $ _____
--Source _____

Interest, Dividends, etc $ _____
--Source (include supporting documents)

Rent Income $ _____
--Include rent expenses applicable to income

Social Security Benefits $ _____

Other Income $ _____

_____ $ _____

_____ $ _____

--Indicate Source

ASSETS

Please indicate asset value and any amounts that are still owed.	Asset Value	Amount Owed	Monthly Payment
1. Value of Principal Residence - 1st Mortgage	$	$	$
2nd Mortgage	$	$	$
2. * Value of Secondary Residence	$	$	$
Indicate type of residence and address			
Cabin, Vacation Home, Condo, Time Share, etc			
3. * Value of other property	$	$	$
Indicate type of property and address	$	$	$
Rental property, Lots, Farm Ground, Investment Property, etc.	$	$	$
4. Vehicles:			
1 - Year _____ Make _____	$	$	$
2 - Year _____ Make _____	$	$	$
3 - Year _____ Make _____	$	$	$
4 - Year _____ Make _____	$	$	$
5. * Boats, Recreational Vehicles, Motorcycles,	$	$	$
ATV's Jet Skis, Campers, etc	$	$	$
Please indicate type of vehicle	$	$	$

6. Savings account balance	$
Institution _____	$
Institution _____	
7. Checking account balance	$
Institution _____	$
Institution _____	
8. * Investments	$
Stocks, Bonds, CD, 401K, IRA's etc	$
Indicate Source	$

9. * Other assets	$	$	$
Includes farm and business equipment, etc	$	$	$
Indicate asset	$	$	$

***Items 2, 3, 8 & 9 - Please provide a description of these items on a separate sheet of paper**

EXPENSES

For debts not listed elsewhere on application

	To Whom Owed	Amount Owed	Monthly Payment
Utilities			
Electric			
Gas			
Telephone-House			
Telephone-Cell			
Trash			
TV/Cable			
Water			
Sewer			
Food			
Medical Bills			
-Physician and/or facility name			
Hospitals			
Physicians			
Dentist			
Other			
Credit Cards			
-Indicate if balance is medical			
Property Taxes			
Insurance			
Gas/Vehicle Maintenance			
Other Debt			

*If additional debt, please include on a separate sheet of paper

This is to advise that I have pursued all other avenues possible, including private insurance and governmental and charitable agencies providing funding and relief from financial obligations, as well as Public Aid. Therefore, I hereby request that Fayette County Hospital make a determination of my eligibility for the Financial Assistance Program. I understand that the information that I submit concerning my income, household size, assets and expenses and medical bills is subject to verification by Fayette County Hospital personnel. I also understand that if the information that I submit is now or at any time in the future is determined will result in current and/or retroactive denial of financial assistance and that I will be liable for services rendered.

I further understand that this financial information will not be shared with anyone outside the hospital without my written authorization.

I certify that all the information in this form is true and correct

Guarantor Signature _____ Date _____

Spouse Signature _____ Date _____