Warner Hospital & Health Services, 422 W White Street, Clinton, IL 61727, (217) 935-9571

APPLICATION FOR
DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Warner Hospital & Health Services/Family Medicine determine if you can receive free or discounted services or other public programs that can help pay for healthcare. Please submit this application to the hospital. Please complete this form and submit it to the hospital business office in person or by mail to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient Name:	
Spouse/Partner/Guarantor Name:	
Address:	
Home Phone:	Cell Phone:
Employer Patient/Guarantor:	Start Date:
Employer Address:	
Spouse/Partner Employer:	Start Date:
Employer Address:	

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. _____ (Social Security Number)

	Name	Age	Relationship
Applicant and Dependent Family Household Members			

Asset information is not used to determine discount eligibility for Outpatient Services

Assets and Estimated Asset Values

Checking:	**Savings:**	**Stocks:**	**Certificates of Deposit:**
Mutual Funds:	**Autos/Vehicles:**	**Real Estate Property:**	**Health Savings or Flex Spending Accounts:**

Significant Personal Circumstances:

Offered Repayment Plan:

COMPLETE THE INFORMATION ON THE BACK OF THIS PAGE

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(If patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient is not required to complete the monthly obligation section)

Monthly Income-Source	Amount	Monthly Obligations	Amount
Gross Wages (include self-employment)		Rent / Mortgage	
Retirement Income		Utilities	
Social Security		Food	
Social Security Disability		Transportation	
Unemployment Compensation		Medical Expenses	
Alimony / Spousal Support Received		Child Care	
Veteran's Pension or Veteran's Disability		Loans	
Other - Describe		Other Expenses (list on separate paper)	
Total Monthly Income		Total Monthly Expenses	

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.

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, 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 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.

_____ _____

Date and Time **Signature**

_____ _____

Date and Time Received **Employee**

OPTIONAL

We are required to ask the following demographic information. ***Your response or lack thereof has no influence on financial assistance determination.***

Race: _____

Ethnicity: _____

Sex: _____

Preferred Language: _____

Complaints or concerns with the uninsured patient discount application or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at (877)305-5145.
https://www.illinoisattorneygeneral.gov/consumers/healthcare.html

Warner Hospital & Health Services is an equal opportunity provider and employer.