



Compassionate Care... Close to Home

**Financial Assistance Application**

We are pleased that you have decided to apply for our financial assistance program at Massac Memorial Hospital. Our goal is to help you in any way possible and make this process as easy as possible for you. This program is provided as a community service for the hospital’s service area. If you are unsure whether you are within the service area, please call the Patient Financial Counselor at 618-524-2176, ext. 253.

Before we can process your application, *all* documents that apply to your situation listed on this page below are required prior to reviewing your application. We are here to help in answering your questions in person, by telephone or email. Patient Financial Service Department hours are Monday through Friday, 7:30 a.m. to 4:30 p.m. The phone number to reach our financial counselor is 618-524-2176, ext 253 and her email address is [delfinab@massachealth.org](mailto:delfinab@massachealth.org).

The application process is as follows: Once we receive the completed application and required documentation, the application will be reviewed and a determination will be made at the end of the month. The hospital’s financial counselor will notify you in writing if you were approved or denied. The letter will include the percentage and the dollar amount of assistance you qualify for, and in some cases the remaining dollar amount that you are responsible to pay.

If you have any questions or need any additional assistance, please do not hesitate to call, email or come to the business office for help. Thank you for choosing Massac Memorial Hospital as your healthcare provider, we are looking forward to serving you in the future. You may also obtain this application and instructions on our hospital website at [www.massachealth.org](http://www.massachealth.org).

**\*\*\*\*DOCUMENTS TO BE TURNED IN WITH COMPLETED APPLICATION\*\*\*\***

**\*\*\*\*PLEASE PROVIDE ALL THAT APPLY TO ANYONE LIVING IN YOUR HOUSEHOLD\*\*\*\***

- ❖ Medicaid denial letter from the Department of Human Services or current medical card for the patient
- ❖ The last two years tax returns that you have filed including W2’s/1099’s for everyone in the household
- ❖ Proof of income for anyone receiving income living in the household
  - \*If working provide all paycheck stubs for the most recent month
  - \*If receiving unemployment benefits provide check stub or unemployment determination letter
  - \*If income is social security, retirement fund, pension, rental property, Earn Fair or General Assistance provide document from the source of the income stating how much you receive
- ❖ If you receive any type of assistance from any source please provide documentation of the assistance amount
- ❖ If your income has changed since your last tax return, and/or you have not filed taxes or you have no income you must provide a written explanation describing your situation and how you are supporting yourself
- ❖ If you are disabled provide proof of disability or if on work restriction provide order of restriction
- ❖ Outstanding hospital bills only, *other than* Massac Memorial Hospital bills
- ❖ Rent or mortgage payment receipts or payment book for one month
- ❖ Copy of utility bills including gas, electric and water
- ❖ Three months of checking and savings statements

**Disclaimer and Authorization:**

I authorize Massac Memorial Hospital to obtain a consumer credit report on my behalf to process my application if necessary. This information will only be used for the purpose it was intended. I also understand that Massac Memorial Hospital will not share or disclose the information with any third party vendor unless I give the proper authorization. Massac Memorial Hospital will not supply me a copy of this report; it will remain in the hospital’s financial record. I also authorize Massac Memorial Hospital to verify all the information given by me in order to process my application.

Applicant’s Name \_\_\_\_\_ Applicant’s Signature \_\_\_\_\_  
Date \_\_\_\_\_

**\*\*\*\*PLEASE RETURN THE APPLICATION AND DOCUMENTS WITHIN 10 DAYS\*\*\*\***

# Massac Memorial Hospital Financial Assistance Application

## **Patient Information or Legal Guardian Information if Patient is a Minor**

Patient/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer & Position or Source of Income \_\_\_\_\_

Annual Gross Income or Hourly Pay/Hrs per Wk & How Often Paid \_\_\_\_\_  
Full or Part-Time (Circle One)

Health Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

## **Spouse or Any Other Adults in Household (Use Back of Sheet if Necessary)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Employer or  
Source of Income \_\_\_\_\_ Position \_\_\_\_\_

Annual Gross Income or Hourly Pay/Hrs per Wk & How Often Paid \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## **Dependent (s) Information (Use Back of Sheet If Necessary)**

Number of dependents \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

## **Asset Information-Please Answer Yes or No**

Automobile \_\_\_\_\_ Recreational Vehicles \_\_\_\_\_ Rental Property \_\_\_\_\_ Do you own a business \_\_\_\_\_

Name of Business \_\_\_\_\_

Checking Account \_\_\_\_\_ Bank Name \_\_\_\_\_ Balance \_\_\_\_\_

Savings Account \_\_\_\_\_ Bank Name \_\_\_\_\_ Balance \_\_\_\_\_



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## **Financial Assistance Program Instructions**

If you are interested in our financial assistance program, the following will give you options for obtaining and completing an application and understanding the application process.

Applications can be requested by phone, mail or in person at the hospital's Patient Financial Services Department. The department's hours of operation are Monday – Friday 7:30 a.m. – 4:30 p.m. and the phone number is 618-524-2176. You may also print your own application from the hospital's website which is [www.massachealth.org](http://www.massachealth.org) by clicking on the financial assistance link on the hospital's homepage.

Once you read through the application and instructions, you should have a clear understanding of our program. If you have any questions please do not hesitate to call the hospital's patient financial counselor at 618-524-2176 extension 253, Monday through Friday 7:30 a.m. to 4:00 p.m.

1. If you are not currently enrolled in the Illinois Medicaid program, you will need to apply for a medical card at your local Department of Human Services office otherwise known as your local public aid office, or obtain a letter that says you do not qualify for any medical programs. If you do not have a current state medical card, it is very important that you apply or obtain the letter as soon as possible. Your financial assistance application cannot be approved without current Medicaid eligibility or proof that you were currently denied for Medicaid within three month's of the date of your financial assistance application.
2. The next step is to begin to gather the required documents. Below is a listing of the required documents if they apply to your situation.
  - a. Proof of income for anyone receiving income in your household, if applicable.

If the income is from a job or unemployment benefits you will need to provide one month of recent pay check stubs. If you are not receiving unemployment yet, but have received a determination letter you will need to provide that letter.

If you receive income from the Social Security Administration you will need the benefit letter which is mailed to you at the beginning each year for the current year. If you do not have your letter for the current year you may call 800-772-1213 to speak to a social security representative and request another letter to be mailed to you.

If you receive income or assistance from any other source, such as retirement funds, pensions, rental properties, food stamps, general assistance from the state then you must provide proof of the amount you receive from the source of income/assistance.
  - b. If your income has recently changed, and/or you have not filed taxes, you will need to provide a written statement explaining what caused the change in income, why you have not filed taxes and how you are paying your living expenses.
  - c. If you are disabled or have been put on work restriction, you will need to supply proof of disability or proof of work restriction.

- d. If you have outstanding hospital or doctor's bills other than what has been acquired at Massac Memorial Hospital, you should provide copies or statements of those bills. If you have a rent or mortgage payment, you need to provide a receipt or payment book for one month's payment.
  - e. If you pay any utilities for your household including gas, electric, water or sewage, you need to provide a receipt or bill for one month's payment.
  - f. If you have a checking or savings account, you need to provide three months of statements for each of your accounts.
3. When you have completed the above instructions, you will need to print and sign your name and enter the date on the first page of the application. Then complete the second page of the application filling in each blank. If you cannot fill in a blank because the item does not apply to you, please fill the blank in with N/A or mark a line through the blank.
  4. Since it may take several weeks to receive your response from the Department of Human Services, you should return your completed application and required documents to the patient financial counselor as soon as possible. Your application will be held until your DHS denial documentation is received. (If you are not able to bring in copies of your documents, you may bring the originals and we will make copies and give you back the originals).
  5. Once your completed application and all required documents are received by the financial counselor, they will be reviewed at the end of the current month. The determination of financial assistance is based on the patient's household income, how many people that income is supporting and at what level within the federal poverty guidelines the income falls. The assistance can range from zero to 100%, and will change in 10% increments depending on how many people live in the household compared to the total household income. You will be notified of the results of your financial assistance by letter which will be mailed to the address you provide on your application. The letter will notify you if you are approved, denied or if reduced payment arrangements are approved. The letter will also include the percentage and dollar amount of assistance you qualified for, and in some cases will include any remaining dollar amount that you would still be responsible for paying. If there is a remaining amount left as your responsibility we will work with you to set a reasonable payment arrangement. If you have any questions regarding the financial assistance application or the application process, please call Massac Memorial Hospital at 618-524-2176.

Thank you for choosing Massac Memorial Hospital as your preferred health care provider.