HARDIN COUNTY GENERAL HOSPITAL & CLINIC
"Caring For Your Family – With Ours"
6 Ferrell Road * P.O. Box 2467
Rosiclare, Illinois 62982
Hospital Phone: (618) 285-6634 Fax: (618) 285-3564
Clinic Phone: (618) 285-2800 Fax: (618) 285-2804
www.ilhcgh.org

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Financial Assistance Program/ Charity Care Application

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Hardin County General Hospital and Clinic determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

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, for which you may be asked to apply. This assistance will be made without discrimination based upon race, color, creed, national origin, gender, sexual orientation, inability to pay or other grounds unrelated to individuals need for these services.

Please complete this application within 60 days following the date of discharge or receipt of outpatient care to apply for financial assistance. Submit completed applications and return:

1. In person to the Credit Manager Office behind Front Hospital Lobby.
2. Fax to Hardin County General Hospital attention Credit Manager at 618-285-3564.
3. By mail to: Hardin County General Hospital, 6 Ferrell Road, PO Box 2467, Rosiclare, IL 62982 Attn: Credit Manager.

Any other questions or concerns? Contact Hardin County General Hospital Credit Manager by calling 618-285-6634 ext. 301 or email: Kathy.jackson@ilhcgh.org.

Persons requiring medical care may request a determination of eligibility from the Credit and Collections personnel, prior to the service, after the service is provided, or even after collection action has been initiated: however, the hospital reserves the right to require proof of need. An uninsured patient will automatically qualify for free care if they meet the **presumptive eligibility requirements as set forth in the FAP policy.** The patient acknowledges that he or she will make 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.
The following supporting documents will be needed to submit with your application:

Most recent Federal Tax Return, including W-2s, 1099s and/or Schedule C.
Pay check stubs or signed statement from an employer.
Current bank statements.
Any other statements you receive from income sources (Social security, unemployment, alimony/child support, retirement/pension, etc.).
Self-employment records.
Worker's compensation benefits.

APPLICANT INFORMATION:

Did you have health insurance at the time of your service? If yes, please provide you insurance information and a copy of your insurance card.
Yes___ No___ Insurance Company:_____ Member ID:_____

IF NO, have you applied for Medicaid? Yes_____ No_____
If yes, what is the status of your Medicaid application? Approved___ Denied___ Pending____

Is your service related to an auto accident? Yes___ No___ IF Yes,
Insurance Company_____ Insurance Policy Number_____
Insurance Phone Number_____

Were you a victim of an alleged crime? Yes_____No_____

Prompt determination of eligibility will be based on income level set by the current Department of Health and Human Services Poverty Guidelines, using the Hill-Burton program income qualifications guidelines:

Poverty Level	100%	125%	200%	300%	400%
	Discount percent applied to Poverty Level				
Family Size	100%	100%	100%	50%	30%
1	$14580	$18225	$29160	$43740	$58320
2	$19720	$24650	$39440	$59160	$78880
3	$24860	$31075	$49720	$74580	$99440
4	$30000	$37500	$60000	$90000	$120000
5	$35140	$43925	$70280	$105420	$140560
6	$40280	$50350	$80560	$120840	$161120
7	$45420	$56775	$90840	$136260	$181680
8	$50560	$63200	$101120	$151680	$202240
For each additional person, add	$5140	$6425	$10280	$15420	$20560

* Based on the HHS **2023** Poverty Guidelines (http://aspe.hhs.gov/poverty/index)
Department of Health and Human Services, Community Service Administration-Federal Register Volume 69 No.30
Maximum that can be collected is 25% of gross annual income.

If you are uninsured, a Social Security number is not required to qualify for free or discounted care.

DEMOGRAPHICS:

Name (First, Middle, Last)			DOB: Social Security #:
Street			
City	State	Zip	Telephone
Occupation		Employer	

INCOME:

Source	Self	Spouse	Other	Total
Gross Wages				
Farm or self-employment				
Public Assistance				
Social Security/SSI				
Unemployment Compensation				
Workman's Compensation				
Strike Benefits				
Alimony				
Child Support				
Military Family Allotments				
Pension				
Dividends, Interest, Rent				
Other				
Total Income				

*If 0 income is listed, you must bring a letter from whomever helps support you financially.
(This is for informational purposes only, that individual's income will not be a factor in eligibility)

Please check all benefits you currently receive: _____WIC_____SNAP_____

Family Members Living in Household:

Dependent Name	Date of Birth	Relationship	Social Security #

OPTIONAL: In accordance with the Illinois Hospital Uninsured Patient Discount Act, we are required to ask the following. Completion is Optional. Responses or nonresponses will not have any impact on the outcome of the application.

RACE: ____ White ____ Black or African American ____ Asian ____ Other____
ETHNICITY: ____Hispanic ____ Non-Hispanic
GENDER: ____ Male ____ Female

PREFERRED LANGUAGE: _____,

The Financial Assistance Program application, Plain Language summary and FAP policy is currently available in English, if you need assistance with interpretation in another language, please contact the hospital listed below.

I/We do hereby certify that the information provided above is accurate and a true representation of my/our financial information. I/We understand that insurance payment or valid denial and completion of this application does not relieve me/us of the financial obligations to Hardin County General Hospital and Clinic. I/We also understand that falsification of any information submitted with this application will result in denial of application. I/We agree to provide the necessary verification of my/our income and authorize Hardin County General Hospital and Clinic to make all inquiries that the hospital deems necessary to verify the accuracy of the statements made herein, including but not limited to procuring a credit report from a credit bureau and/or other financial institutions. Hardin County General Hospital and Clinic reserves the right to deny any application upon their review.

Signed:_____ Date:_____

Signed:_____ Date:_____

Revised: 8/2/2022
DFS:JP