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

Financial Assistance Program/ Charity Care Application

Hardin County General Hospital will give financial assistance to uninsured individuals who are financially unable to pay for medical care excluding deductible, insurance co-payments, and IDPA spend downs. Applicants who appear to be Medicaid eligible will require a written denial of coverage. This assistance will be made without discrimination based upon race, color, creed, national origin, gender, sexual orientation or other grounds unrelated to individuals need for these services.

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 be initiated: however, the hospital reserves the right to require proof of need. This requirement may be proof of income in the form of paystubs, W-2's, 1099 forms, unemployment checks, bank statements or state and federal tax returns or any other information that is reasonable and necessary to substantiate the applicant's income.

Once the information is complied and reviewed by the Credit and Collections personnel, and a determination is made that the Financial Assistance Application meets the criteria, it will be forwarded to Administration for review. 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%	50%	30%	10%
1	$12760	$15950	$25520	$38280	$51040
2	$17240	$21550	$34480	$51720	$68960
3	$21720	$27150	$43440	$65160	$86880
4	$26200	$32750	$52400	$78600	$104800
5	$30680	$38350	$61360	$92040	$122720
6	$35160	$43950	$70320	$105480	$140640
7	$39640	$49550	$79280	$118920	$158560
8	$44120	$55150	$88240	$132360	$176480
For each additional person, add	$4480	$5600	$8960	$13440	$17920

* Based on the HHS 2020 Poverty Guidelines (http://aspe.hhs.gov/poverty/index)

The applicant will receive notice as to the approval or denial of Financial Assistance/Charity Care. The applicant will also be instructed to call or write Hardin County General Hospital for further information on payment plans.

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Name (First, Middle, Last)			SSN
Street			
City	State	Zip	Telephone
Occupation		Employer	

Income

Source	Self	Spouse	Other	Total
Gross Wages				
Farm or self-employment				
Public Assistance				
Social Security				
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 enclose a copy of your state and federal income tax returns if applicable.

Family Size

Name	Date of Birth	Relationship
Self		
Spouse		
Dependent		
Dependent		
Dependent		

I believe the information provided for this application is true to the best of my knowledge.
I furthermore agree that Hardin Co General Hospital has taken steps to assist me and or my family following policy and Federal Poverty Guidelines.

_____ _____

Patients Signature Date

_____ _____

Witness Signature Date

Revised: 1/9/2018
DFS:JP