Carlinville Area HOSPITAL

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Carlinville Area Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

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.

As a courtesy to our patients, Carlinville Area Hospital will submit a claim to your insurance company. It is important to present accurate and complete personal and insurance information at the time of registration. We ask for your assistance in paying your portion of emergency room, outpatient, and inpatient charges at the time of service. Accepted forms of payment include cash, check, debit card, Master Card, Visa & Discover.

We gladly accept payments that are within our guidelines. Our Payment Policy is as follows:

Balances under $1,000.00 need paid in equal monthly payments within 12 months

Balances over $1,000.00 need paid in equal monthly payments within 24 months

** Minimum payments of at least $50.00 per month

We accept automatic payments each month from your checking, savings, debit or credit card. You choose which day of the month you would like your payment. You may also make payments online through our website at www.cahcare.com

If you have accounts at our new customer service are,
Please contact them at (855) 262-4778 to set up payments.

If you have accounts that have been turned over to the credit bureau, CCM,
Please contact them at (800) 325-6611 to set up payments.

For concerns, questions, a dispute on your account, or if you need assistance with payment arrangements, please call (217) 854-5092 or 855-262-4778 Monday through Friday from 8:00 a.m. to 4:30 p.m. excluding holidays. Please be prepared to provide Patient Name, Patient Date of Birth, Account Number, and Date of Service with your request.

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VERIFICATION OF INCOME

** All items below are required **

Patient Name _____

☐ 1. Paycheck stubs (including unemployment or work comp) for all household members for the past two (2) months or a statement of monthly benefits from Social Security for all members who receive Social Security benefits.

☐ 2. Complete copy (all pages) of your Federal Tax Return from the previous calendar year or your 1099 Benefit Statement from Social Security from the previous calendar year.

If you did not file taxes due to lack of income or employment, please sign below. Your signature is needed for our records.

_____ _____

Patient Signature Spouse Signature

☐ 3. Complete copies (all pages) of your checking and/or savings account statements for the past three (3) months.

If you do not have a checking and/or savings account, please initial here _____.

☐ 4. Completed financial assistance application.

Failure to provide the above information will result in an incomplete application. Providing false information or excluding required information may result in denial of financial assistance.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days after receipt of the form.

Carlinville Area Hospital Financial Assistance Application

Accounts Receivable Information

Patient Name _____ Account Number _____

Guarantor Name _____ Date of Birth _____

Address _____ Social Security _____

_____ Phone _____

Email _____

Was patient an Illinois resident when care was rendered by the hospital? Yes _____ No _____

Household Information

Please list all members of your household

Name:	Age:	Relationship:
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

If dependent child is over 18 must provide proof of dependency.

Employment Information

Employer Name _____ Spouse Employer _____

Address _____ Address _____

_____ _____

- If you are currently unemployed, please include the date you were last employed, why you left, and the date you plan on returning to work below.

_____

Income Sources – Verification Required

Do not leave this section blank. If an item does not apply, indicate so with a zero or N/A.

Gross Wages – Guarantor _____ Gross Wages – Spouse _____
Public Assist/Welfare _____ Workers Comp _____
Social Security:_____ Unemployment_____
Alimony/Child Support:_____ Pensions:_____
Dividends/Interest:_____ Rents/Royalties:_____
Estates/Trusts:_____ Other:_____

Asset Sources

Checking Account Number _____ Bank Name _____
Savings Account Number _____ Bank Name _____
Stocks_____ Bonds:_____

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 or 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 provided 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.

I/We hereby certify that I/we are of legal age and that the forgoing statements are true and complete. They are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain your property, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made herein, and to determine my/our credit worthiness, including, but not limited to procuring consumer reports from consumer reporting agencies, and credit information from bank and other financial institutions.

Signature of Applicant_____ Date_____

Signature of Spouse_____ Date_____