Memorial Hospital and affiliates, PO Box 160, Carthage, IL 62321, (217)357-6591

Application for Determination of Eligibility for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Memorial 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 Patient Account Department.

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.

Applicant			
	First	**Middle**	**Last**
Address			
	Street/PO Box	**City**	**State/Zip Code**

Employer	**Home Phone**	**Social Security Number**

Family members or residents of current Household	**Name**	**Date of Birth**	**Relationship**	**Name**	**Date of Birth**	**Relationship**
			Self-Applicant			

Patients may be eligible for financial assistance as presumptive eligibility without further evaluation. Please answer the questions below to assist in discovering if presumptive eligibility is possible.

1. Was the patient involved in an accident? **YES** or **NO**
2. Is the patient a victim of crime and receiving treatment for this crime today? **YES** or **NO**
3. Is the patient currently receiving any of the following state or federal programs such as food stamps, free lunches, WIC, energy assistance, etc.? **YES** or **NO**

Please provide copies of one or more of the following documents if available with your application for income verification.

Most recent W-2, last three months of payroll/unemployment check stubs, most recently filed tax return, 1099-R, SSA-1099, social security letter, disability income, self-employment income/expenses, and/or any other household income. Include anyone in the household that is related with income.

Form #5157 Dev. 05/09, Rev. 01/11, 04/13, 01/14, 02/16, 08/18, 7/19, 02/21, 09/21, 03/24, 12/24

Please review and sign below

I acknowledge that I have made a good faith effort to provide all information requested in the application to assist the hospital in determining whether I am eligible for financial assistance. I certify that the information in this application is true and correct to the best of my knowledge.

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	Signature of Responsible Party
_____	_____
Date Received	Memorial Hospital Employee