Sarah Bush Lincoln

Financial Assistance Program

Important:

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Sarah Bush Lincoln 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 Sarah Bush Lincoln/Patient Financial Services 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.

Please complete this form and submit it to Sarah Bush Lincoln/Patient Financial Services department in person or by mail to apply for free or discounted care within 240 days following the date the first billing statement is mailed to the patient.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Sarah Bush Lincoln in determining whether the patient is eligible for financial assistance.

We will work with community members to help simplify the business aspect of our relationship. For example, we will help patients obtain payment from third parties such as Medicaid and Medicare by answering their questions and assisting them with applications. We offer financial assistance for persons who meet the financial terms once they've submitted the necessary paperwork, and we invite patients to apply for financial assistance when they cannot cover account balances after we've received payments from third-party payers (like Medicaid, Medicare and insurance companies).

If you have any questions about the SBL Financial Assistance Program, please call Patient Financial Services between 8 am and 4:30 pm, Monday through Friday at **(800) 381-0040**.

Financial Assistance forms may be downloaded from **www.sarahbush.org**

To apply for the IL Hospital Uninsured Discount, proof of residency and one of the following proof of income documents is required: recent tax return; W-2 or 1099; two most recent pay stubs; written verification from employer; or one other reasonable form of income verification.

Copies of the following forms must be submitted with your application (if applicable) to apply for all other financial assistance programs:

- ❑ Most recent tax forms. Last two years for those who are self employed.
- ❑ Most recent check stub(s) from all jobs.
- ❑ Unemployment check stub listing start date and amount.
- ❑ Divorce decree stating child support paid or alimony & child support received.
- ❑ Letter from public programs (Social Security, Veterans, Public Aid) listing amount received.
- ❑ Verification of all other income.
- ❑ Public Aid approval or denial letter if applicable - pregnant, dependent children, disabled, blind, over age 65.

Bills will continue to be sent until a completed application is returned. Before the application may be processed, copies of supporting forms must be submitted with application or mailed to:

Patient Financial Services
Sarah Bush Lincoln
1000 Health Center Drive; PO Box 372
Mattoon, IL 61938

The mission of Sarah Bush Lincoln is to provide exceptional care for all and create healthy communities.

Revised 06/2016

Sarah Bush Lincoln

Financial Assistance Program

Enhanced to better serve people with greater financial needs.

Sarah Bush Lincoln

Trusted Compassionate Care

Application for SBL Financial Assistance

If you need any help with this form, please call 800-381-0040.

PATIENT INFORMATION

Name _____

Date of Birth _____

Address _____

_____

Social Security # _____
(not required if you are uninsured)

Telephone or cell phone number _____

GUARANTOR INFORMATION

Spouse, Partner and Parent or Guardian for a minor, must complete the following.

Guarantor Name _____

Guarantor Address _____

_____

Guarantor phone number _____

FAMILY/HOUSEHOLD INFORMATION

Dependent's Names:

Name _____ **Birthdate** _____

Name _____ **Birthdate** _____

Name _____ **Birthdate** _____

Name _____ **Birthdate** _____

Name _____ **Birthdate** _____

Name _____ **Birthdate** _____

PATIENT'S FAMILY INCOME & EMPLOYMENT INFORMATION

Patient's Employer Name _____

Patient's Employer Address _____

Patient's Employer Phone _____

Guarantor/Spouse/Partner Employer Name

_____

Guarantor/Spouse/Partner Employer Address

_____

Guarantor/Spouse/Partner Employer Phone

_____

INSURANCE INFORMATION

❑ **Patient** ❑ **Guarantor** ❑ **Spouse** ❑ **Partner**

Health Insurance Name _____

❑ **Medicare**

❑ **Medicare Supplement Name** _____

❑ **Medicaid**

ANNUAL INCOME:

Patient wages	$___,___.00
Guarantor/Spouse/Partner's wages	$___,___.00
Farm or Self-employment Income	$___,___.00
Temporary Assistance for needed families	$___,___.00
Social Security/Disability	$___,___.00
Unemployment/Worker's Compensation Benefits	$___,___.00
Alimony/Child Support/ other Spousal Support	$___,___.00
Pension/Annuities	$___,___.00
Veteran's Pension	$___,___.00
Veteran's Disability	$___,___.00
Other Income	$___,___.00
Total gross income from all sources for the past 12 months	$___,___.00

CERTIFICATION

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.

_____
Applicant Signature

_____
Signature Date

Please see back panel for additional information.