Clay County Hospital

Dear Patient / Guarantor:

Attached please find the Financial Assistance Application.

Before your application can be approved, you must attach the following information with your submitted application.

- ☐ Prior year tax return if filed with W-2's for everyone working in your household and current pay stubs for the two most recent months of employment for everyone working in your household.
- ☐ Social Security and/or Disability benefit statement for everyone who receives Social Security or Disability payments.
- ☐ An Illinois IDPA Medicaid award or denial letter dating within six months from the date this application is submitted for everyone for whom you are applying for Financial Assistance.
- ☐ Any other type of monetary benefits in addition to those listed above that anyone in your household is currently receiving.

This application shall expire 60 days from the date from which it was generated if not submitted.

Sincerely,

Financial Counselor
(618) 844-3147

Clay County Hospital

FINANCIAL EVALUATION

Date Sent:	Account Number:	Account Number:
Please Return By:	Account Number:	Account Number:
Date Returned:	Account Number:	Account Number:

PATIENT INFORMATION

Name of Patient:			
Age:	Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced	Telephone Number:	Social Security Number:
Street Address:			
City:		State:	Zip Code:
Name of Person Responsible for Bill:			Relationship:
Street Address:			Telephone:
City:		State:	Zip Code:

EMPLOYMENT

Name of Patient's Employer:		Name of Responsible Person's Employer:	
Occupation:		Occupation:	
If Unemployed – Name of Last Employer:	How Long Unemployed:	If Unemployed – Name of Last Employer:	How Long Unemployed:

LIST BELOW ALL MEMBERS OF HOUSEHOLD (Exclude Patient)

Name	Age	Relationship to Patient

Do you have health insurance coverage available? ☐ Yes ☐ No List Coverage: _____

If yes, why not available for this date of service? _____

_____

If no, please indicate the reason for lack of insurance coverage: Insurance cost too high? ☐ Yes ☐ No Pre-Existing Condition? ☐ Yes ☐ No

Other – please describe: _____

Have you applied for Medicaid? ☐ Yes ☐ No Date Applied: _____ If denied, date: _____

Reason For Denial: _____

Please attach a copy of the Medicaid denial letter, if denied

DOB:
ADMIT:
ADM:
PCP:
MR #:

HSV:
AGE: SEX:
RM/BED: /
#:
#:
PAT #:

MONTHLY INCOME (Attach Copy of Proof of Income)			
	Patient	**Spouse**	**Other**
Wages (Gross)			
Social Security			
Pensions			
Unemployment / Work Comp			
Alimony / Child Support			
Government Assistance			
Disability Payments			
Strike Benefits			
Scholarships / Grants			
Dividends / Interest			
Other, List			

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I verify the information provided is correct and complete. I authorize verification of any information and understand that additional documentation may be requested. If any information is found to be false, the financial arrangement or assistance may be voided.

Signature of Patient / Responsible Party:	Date:

DOB: AGE: SEX: HSV:
ADMIT: RM/BED: /
ADM: #:
PCP: #:
MR #: PAT #: