Washington County Hospital

Nashville, IL

Financial Assistance Application Form

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Washington County 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.

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 following the date of discharge or receipt of outpatient care.

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

Please return the form to**: Washington County Hospital, Attention: Financial Assistance Advisor**
705 South Grand Avenue
Nashville, Illinois 62263

DEMOGRAPHIC INFORMATION

Patient Information *(or Applicant in behalf of patient)*

Are you an Illinois resident? ☐Yes ☐No Are you homeless? ☐Yes ☐No

Name and Permanent Home Address:

_____ _____ _____
Last Name *First Name* *MI*

_____ _____ _____ _____ _____
Street *Apt #* *City* *State* *ZIP Code*

Where are you currently residing, if not at home?

_____ _____ _____ _____ _____
Street *Apt #* *City* *State* *ZIP Code*

Phone and Email: Preferred Contact:

Home: ( ) _____ ☐

Work: ( ) _____ ☐

Cell: ( ) _____ ☐

E-mail: _____ ☐

Other: _____ ☐

Date of Birth:

_____ / _____ / _____

Age: _____

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

_____ - _____ - _____

Co-Applicant (Spouse or Parent Information if patient is a minor)

Name and Home Address:

_____ _____ _____

Last Name *First Name* *MI*

_____ _____ _____ _____ _____

Street *Apt #* *City* *State* *ZIP Code*

Where are you currently residing, if not at home?

_____ _____ _____ _____ _____

Street *Apt #* *City* *State* *ZIP Code*

Phone and Email: Preferred Contact:

Home: ( ) _____ ☐

Work: ( ) _____ ☐

Cell: ( ) _____ ☐

E-mail: _____ ☐

Other: _____ ☐

Date of Birth:

_____ / _____ / _____

Age: _____

Social Security #:

_____ - _____ - _____

EMPLOYMENT/INCOME SECTION

Patient (or Applicant) Employer Information

Are you currently employed? ☐Yes ☐No

If no, how are you meeting living expenses?

_____

_____

_____

_____

Patient Employer:

_____

_____

Employer Name

_____

_____

Address *Phone*

Is your spouse currently employed? ☐Yes ☐No

Spouse Employer:

_____

__

Employer Name

_____

_____

Address *Phone*

Monthly Income:	Patient (or Applicant)	Spouse
Gross Monthly Wages	$_____	$_____
Unemployment	$_____	$_____
Workers Compensation	$_____	$_____
Disability	$_____	$_____
Social Security	$_____	$_____
Pension	$_____	$_____
Other	$_____	$_____
Less Child Support Payments Made	$_____	$_____

ASSETS SECTION

List the value of each asset.

Checking/Savings Accounts:

Checking Account(s): $_____

Savings Account(s): $_____

Investments:

Stocks: **$_____**

Certificates of Deposit (CDs) **$_____**

Mutual Fund(s): **$_____**

Property:

Car(s): $_____

Other Property (excluding your home): $_____

Health Savings/ Flexible Spending Account: $_____

OTHER INFORMATION:

FAMILY SIZE / DEPENDENTS SECTION

Number of people in household: _____

Name of Dependent(s):	Date of Birth	Relationship to Patient
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
	_____ / _____ / _____	
	_____ / _____ / _____	

INSURANCE / MEDICAID SECTION

	Do you have medical insurance?		Insurance Company	Policy Number
	Yes	No		
Patient / Applicant	☐	☐	1. _____ 2. _____	_____ _____
Spouse	☐	☐	1. _____ 2. _____	_____ _____

Have you applied for Medicaid?

☐ Yes – Awaiting approval ☐ Yes – Not Eligible ☐ No

If you have not applied for Medicaid, we may require you to do so. Check all that apply to you:

☐ Blind ☐ Disabled ☐ Pregnant

☐ 19 years or younger ☐ 65 years or older ☐ Have children under age 19 living with you

OTHER INFORMATION:

MONTHLY EXPENSES SECTION

Housing:	$_____	Child Care:	$_____
Utilities:	$_____	Loans:	$_____
Food:	$_____	Other Expenses:	$_____
Car:	$_____	Medical Expenses Owed:	$_____

OTHER INFORMATION:

CERTIFICATION SECTION

I certify that the information in this application is true and complete to the best of my knowledge. I will apply for any state, federal or local assistance 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 in order to verify the accuracy of the information provided in this application. I understand that if the above information is untrue, any financial assistance granted to me may be reversed, I may not be able to get financial assistance in the future and I will be responsible for the payment of the hospital bill.

Applicant Signature: _____ Date: _____/_____/_____