



Hospital Financial Assistance Application

You may be able to received free or Discounted Care. Completing this application will help Roseland Community 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 tire hospital.

If you are Uninsured, a **SS Number is not required to qualify for Free Services 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.

I _____ acknowledged that I had made a good faith effort to provide all information requested in the application to assist the hospital in determining whether I eligible for financial assistance.

Eligibility is based on current Federal Poverty Guidelines, as define in Federal Register. The Family size, total income and extenuating situations are considered in the final determination of financial assistance.

Presumptive Eligibility: Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria established in Section 4500.40 (Source: Amended at 38111Reg 20263), Listed below, whether individually or through the benefits provided to their family, are automatically eligible to receive **free care** and **no proof of income** will be no required. RCH's staff members will verify Eligibility Electronically.

If you demonstrate Presumptive eligibility, you may not need to supply any income information but you still need to sien the applicant certification on the following poses*

- Homelessness
- Deceased with not estate
- Mental Incapacitation, with not one to act on patient's behalf.
- Medicaid eligibility, but with not on date of service or for non-covered service
- Enrollment in the following assistance programs, low -income eligibility at or below 250% of FPG guidelines.
- WIC, SNAP, IL free L& B program, LIHEAP.
- Incarceration
- Personal Bankruptcy
- IHDA, Rental Housing Support Program
- Temporary Assistance for Needy Family

Account Number: _____ Date of Service: _____ Inpatient Outpatient



Family / Household Information

Number of persons in the patient's Family _____

Number of persons who are depends of the patient's _____

Ages of the patient's dependents _____

Patient's family income & Employment information:

Is the patient's spouse or partner (parents *in case of minor*) is currently employed? YES NO Employer information if

apply: name, address and phone #

GROSS MONTHLY FAMILY INCOME

Wages	\$ _____
Self-Employment	\$ _____
Unemployment Compensation	\$ _____
Social Security Income	\$ _____
Social Security Disability	\$ _____
Veterans 'Pension	\$ _____
Veterans' Disability	\$ _____
Workers 'Compensation	\$ _____
Retirement income	\$ _____
TANF	\$ _____
Child Support, Almonry or other spousal income	\$ _____
Other income	\$ _____
TOTAL	\$ _____

Documentation of Family Income included:

- Paycheck stubs, benefits statements, award letters, court orders, federal tax returns
- Health Insurance. Medicare, part D, Medicare Supplemental, Medicaid, Veterans Benefits
- Asset & estimated asset Value: Checking, Savings, stocks, certificate of deposit, Mutual funds, Automobiles, Real property, health savings accounts.

