Hospital Sisters
HEALTH SYSTEM

Belleville, IL
HSHS St. Elizabeth's Hospital

Breese, IL
HSHS St. Joseph's Hospital

Decatur, IL
HSHS St. Mary's Hospital

Effingham, IL
HSHS St. Anthony's Memorial Hospital

Highland, IL
HSHS St. Joseph's Hospital

Litchfield, IL
HSHS St. Francis Hospital

Springfield, IL
HSHS St. John's Hospital

Streator, IL
HSHS St. Mary's Hospital

Chippewa Falls, WI
HSHS St. Joseph's Hospital

Eau Claire, WI
HSHS Sacred Heart Hospital

Green Bay, WI
HSHS St. Mary's Hospital Medical Center
HSHS St. Vincent Hospital

Oconto Falls, WI
HSHS St. Clare Memorial Hospital

Sheboygan, WI
HSHS St. Nicholas Hospital

HSHS Medical Group

Prairie Cardiovascular

FINANCIAL ASSISTANCE APPLICATION

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Hospital Sisters Health System determine if you can receive free or discounted services or other public programs that can help pay for your health care. 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.

CERTIFICATION STATEMENT

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 in this application may be verified to ensure accuracy. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, and financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or Applicant Signature: ______________________________
Date: ______________________________

www.hshs.org

Sponsored by the Hospital Sisters of St. Francis

FINANCIAL ASSISTANCE PROGRAM

Please provide copies of the following items:

- ❑ W-2 withholding statements
- ❑ Most recent federal/state income tax forms
- ❑ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).
- ❑ Forms approving or denying Unemployment, Workers Compensation or Assistance from the Department of Public Aid
- ❑ Statement of annual benefits from Social Security
- ❑ Checking/savings account statements (past 3 months)
- ❑ Other: letter explaining your situation

Your cooperation with Hospital Sisters Health System (HSHS) is extremely important in determining your eligibility for financial assistance. Failure to provide this information will be cause to deny financial assistance.

Please return completed application along with required documentation to the hospital where you received your medical care:

WISCONSIN

EASTERN WISCONSIN

St. Mary's Hospital – Green Bay, WI
St. Vincent Hospital – Green Bay, WI
St. Nicholas Hospital – Sheboygan, WI
St. Clare Memorial Hospital – Oconto Falls, WI

All **Eastern Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
Attention: Financial Assistance Program
PO Box 13508
Green Bay, WI 54307

Local – (920) 433-8122
Toll free – (800) 211-2209
Fax – (920) 431-3161

WESTERN WISCONSIN

St. Joseph's Hospital – Chippewa Falls, WI
Sacred Heart Hospital - Eau Claire, WI

All **Western Wisconsin** completed applications along with all attachments should be sent to the following address:

Patient Financial Services
Attention: Financial Assistance Program
900 West Clairemont Avenue
Eau Claire, WI 54701

Local – (715) 717-4141
Toll free – (888) 445-4554
Fax – (715) 717-4032

ILLINOIS

CENTRAL ILLINOIS

St. John's Hospital – Springfield, IL
St. Francis' Hospital – Litchfield, IL
St. Mary's Hospital – Decatur, IL
St. Mary's Hospital – Streator, IL

All **Central Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
Attention: Financial Assistance Program
2343 South MacArthur Blvd.
Springfield, Illinois 62704

Local – (217) 525-5615
Toll free – (888) 477-4221

SOUTHERN ILLINOIS

St. Elizabeth's Hospital – Belleville, IL
St. Joseph's Hospital – Highland, IL
St. Anthony's Hospital – Effingham, IL
St. Joseph's Hospital – Breese, IL

All **Southern Illinois** completed applications along with all attachments should be sent to the following address:

Patient Accounts Department
Attention: Financial Assistance Program
211 South Third Street
Belleville, IL 62220

Local – (618) 234-8600

FINANCIAL ASSISTANCE APPLICATION

APPLICANT/RESPONSIBLE PARTY INFORMATION

APPLICANT NAME: (last, first, middle initial)

BIRTHDATE:	SOCIAL SECURITY NUMBER:	PHONE NUMBER:

HOME ADDRESS (City, State, Zip):

PREVIOUS ADDRESS (City, State, Zip):

Members of family unit	HOUSEHOLD MEMBER NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT *If Applicant, Self*	Live at home		SOCIAL SECURITY NUMBER	Current Patient?	
				Yes	No		Yes	No
1.								
2.								
3.								
4.								
5.								

PRESUMPTIVE ELIGIBILITY CRITERIA:

Does any of the information below apply to you? If YES, check all that apply Please provide documentation/verification if you check YES to any of the statements below:

- ❑ Homelessness
- ❑ Deceased with no estate
- ❑ Mental incapacitation with no one to act on patient's behalf
- ❑ Medicaid eligibility, but not on date of services or for non-covered service
- ❑ Incarceration in penal institution
- ❑ Enrolled in Temporary Assistance for Needy Families (TANF)
- ❑ Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
- ❑ Enrolled in Wisconsin Department of Health Services Housing Assistance Program

Enrollment in the following assistance for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

- ❑ Woman, Infant and Children Nutrition Program (WIC)
- ❑ Supplemental Nutrition Assistance Program (SNAP)
- ❑ Illinois Free Lunch and Breakfast Program
- ❑ Wisconsin Free Lunch Program
- ❑ Low Income Home Energy Assistance Program (LIHEAP)
- ❑ Wisconsin Home Energy Assistance Program (WHEAP)
- ❑ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
- ❑ Receipt of grant assistance for medical services

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veteran's benefits, Medicaid and/or Medicare? If yes, please provide the following information:

Policy holder: ______________________________

Insurer: ______________________________ Policy Number: ______________

Were you covered or eligible under a spouse/ partner or former spouse/partner's health insurance policy, foreign coverage policy, Health Insurance Marketplace policy, Veteran's benefits, Medicaid and/or Medicare policy for any or all of your medical service?

Former Spouse/partner name: ______________________________ Phone number: ______________

Former spouse/partner address: ______________________________

EMPLOYMENT 1: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):	
SALARY (GROSS): ___________(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ TWICE A MONTH ❑ MONTHLY ❑ ANNUALLY	HOW LONG: _______YR _________ MO	POSITION:

EMPLOYMENT 2: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):	
SALARY (GROSS): ___________(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ TWICE A MONTH ❑ MONTHLY ❑ ANNUALLY	HOW LONG: _______YR _________ MO	POSITION:

UNEARNED INCOME Child support does not need be revealed if you do not wish to have it considered as a basis for repaying this obligation.	TYPE OF UNEARNED INCOME	HOUSEHOLD MEMBER	AMOUNT	PERIOD
	1.			
	2.			
	3.			
	4.			
	5.			

CHILD SUPPORT: NAME OF CHILD (RECEIVING)	NAME OF PERSON / PARENT PAYING	AMOUNT	PERIOD
1.			
2.			

HOME:	NAME AND ADDRESS OF LANDLORD	RENT PMT:	DUE DATE:	CONTRACT PMT:	MORTGAGE PMT:
❑ Rent ❑ Own		PURCHASE PRICE:	DATE PURCHASE:	BALANCE DUE:	ESTIMATED VALUE:

ASSETS/RESOURCES Assets that are counted include: cash, checking and savings accounts, recreational vehicles, real estate other than the home or land you live on, a life insurance policy with a cash surrender value, stocks and bonds.	TYPE OF ASSET	HOUSEHOLD MEMBER	AMOUNT	PERIOD	BANK/ DESCRIPTION

CREDIT/RECURRING ACCOUNTS NAME AND ADDRESS OF CREDITOR	WHAT WAS PURCHASED	AMOUNT FINANCED	UNPAID BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				

CHILD SUPPORT EXPENSES HOUSEHOLD MEMBER MAKING PAYMENT	CHILD NAME	AMOUNT	PERIOD
1.			
2.			

Are you seeking financial assistance for treatment related to: ❑ Workplace injury ❑ Accident ❑ Crime ❑ Cancer

If yes, please provide details: