Touchette
REGIONAL HOSPITAL

# HOSPITAL FINANCIAL ASSISTANCE APPLICATION

***Demographic Section:***

Last Name | First Name

Social Security Number - -

*(If you do not have a Social Security Number, it will not impact your ability to receive financial assistance, but will help the hospital to determine whether you qualify for any public programs)*

| Address | City | State | Zip | Phone number |
|---|---|---|---|---|
| | | | | |

Email Address | Date of Birth

**STOP!** If you currently receive assistance from any of the following and can provide RECENT copies in the applicant's or patient's name, bring a copy to Touchette Regional Hospital Outpatient Registration, and you do not have to complete the remaining portion of this application. *(plan = Charity Presumptive)*

-- Homeless
-- Incarceration in a penal institution
-- Deceased with no estate
-- Temporary Assistance for Needy Families (TANF)
-- WIC
-- Illinois Free Lunch & Breakfast Program
-- Supplemental Nutrition Assistance Program (SNAP)
-- Mental incapacitation with no one to act on the patient's behalf
-- Illinois Housing Dev Authority's Rental Housing Support
-- Bankruptcy within the past 6 month
-- Illinois Housing Dev Authority's Rental Housing Support
-- Low Income Home Energy Program (LIHEAP)

***Family Size/Dependents Section:***

Number of people living in your household

Dependents (living in your home) If more space is needed, please write on back of this sheet

| Name | Date of Birth or Age | Relationship to you |
|---|---|---|
| | | |
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| | | |

***Income Section:***

Employer's Name and City:

Spouse's Employer's Name and City:

If you are not employed, how are you meeting your living expenses?

Include all sources of income including, but not limited to, wages, self-employment, unemployment, disability, social security, pension, child support, pension, and/or any other income sources)

| Source of Payment | Amount | How Often (per week, every 2 weeks, every month) |
|---|---|---|
| | $ | |
| | $ | |
| | $ | |
| | $ | |
| | $ | |
| | $ | |

**Please submit proof of income (Most Recent tax return, pay stub, vouchers, etc.)**

***Certification Section:***

I certify that the information in this application is true and complete. I will apply for any state, federal or local assistance to help pay for these medical expenses. I understand that the information provided may be verified by my medical providers and I authorize them to contact any necessary 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 and I will be responsible for the payment of these medical expenses.

Patient (or Applicant) Signature _____ Date _____

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

Completing this application will help Touchette Regional Hospital determine if you can receive care or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the Touchette Regional Hospital Registration or Customer Service Department within 60 days of receiving the first billing statement.

You may also mail or fax your application and all supporting documentation:

**Touchette Regional Hospital**
**Att: Angie Merten**
5900 Bond Ave
Centreville, IL 62207 Fax: (618) 332-5242