

# APPLICATION FOR FINANCIAL ASSISTANCE

## WHO IS ELIGIBLE FOR CHARITY?

Patients that do not have any coverage or do not qualify for any coverage and request or receive services at Touchette and Kenneth Hall Regional Hospital will be reviewed for eligibility under the Hospital Charity Policy either prior to the service being received or at the time of service. Initial eligibility requirements are:

The patient is an established resident whose primary address is within the Hospital service area.  
or  
The patient is currently established with a primary physician or specialist that is on staff at the Hospital and it is that physician that is ordering the services.

Charity arrangements provided by Touchette and Kenneth Hall Regional Hospitals do not apply to any separate billings from other providers for additional services rendered. The hospital reserves the right to postpone final eligibility approval and the requested service in accordance with regulations and guidelines set forth by the federal and/or the State of Illinois.

### HOW DO I APPLY?

At the time of registration each patient will be reviewed for insurance eligibility and/or for charity eligibility. However, if you want to know if you would qualify for charity prior to the services being rendered, you can mail or deliver this application to:

Touchette Regional Hospital  
5900 Bond Avenue  
Centreville, IL 62207  
Attn: Customer Service

or you can contact Customer Service if you have any questions regarding your eligibility at 618-332-5215.

### WHO WOULD NOT BE ELIGIBLE?

If a patient meets eligibility criteria for any type of coverage including but not limited to Workers Compensation, Auto Liability, Victims of Crime, Medicaid, etc, charity will be postponed until coverage eligibility can be determined. If applicable, the hospital will provide assistance through the Medicaid eligibility process.

Patients that elect to enter the New Vision Program, patients that qualify for grant money from other programs associated with either facility, patients with coverage including those that have coverage but insufficient coverage for the requested service will not be eligible for charity.

### WHEN AM I APPROVED?

The hospital registration system is capable of obtaining charity eligibility confirmation at the time of service; however, if the amount of charity cannot be determined at that time, the patient will be asked to provide additional financial documentation as set out in this application and deliver to Touchette Customer Service or Kenneth Hall ER Admitting within thirty (30) days of the service so that the final determination can be made.

The financial documentation received will assist in the determination as to how much charity the patient will be qualified to receive. The total amount of charity received will be contingent upon the patient's overall financial situation and the Hospital has the right to postpone final eligibility approval and the requested service in accordance with any regulations and guidelines set forth by the federal government and/or the State of Illinois.

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## PERSONAL INFORMATION

Print Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Patients Social Security Number: \_\_\_\_\_

If patient is a minor or a dependent: \_\_\_\_\_  
Print Name of Responsible Party / Relationship

Mailing Address: \_\_\_\_\_  
Street City State Zip

Contact Numbers: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Is the medical treatment requested due to **any type** of injury or accident?  Yes  No

## FINANCIAL INFORMATION

Number of people currently living in the household **OVER** 18 years of age: \_\_\_\_\_

Number of people currently living in the household **UNDER** 18 years of age: \_\_\_\_\_

Current Income (estimate): \_\_\_\_\_ (per month / per year)

Other household Income (estimate): \_\_\_\_\_ (per month / per year)

**TO QUALIFY FOR ELIGIBILITY, please deliver a copy of your prior year Federal Income Tax Form to Touchette Regional Hospital Customer Service or to ER Admitting at Kenneth Hall Regional Hospital. Additional documentation may be required to substantiate financial assistance eligibility.**

## ACKNOWLEDGEMENT

I hereby certify that the above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Patient or Responsible Party on behalf of the Patient

\_\_\_\_\_  
Date