Touchette Regional Hospital

Apply Patient Label Here

HOSPITAL FINANCIAL ASSISTANCE APPLICATION ACKNOWLEDGEMENT

Last Name _____ First Name _____

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 90 days following the discharge or outpatient visit.

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 this application. (plan = Charity Presumptive)

- -- Healthy Women
- -- WIC
- -- Illinois Free Lunch & Breakfast Program
- -- Supplemental Nutrition Assistance Program (SNAP)
- -- Temporary Assistance for Needy Families (TANF)
- -- Illinois Housing Dev Authority's Rental Housing Support
- -- Low Income Home Energy Program (LIHEAP)
- -- Bankruptcy within the past 6 months

APPLICATION GIVEN TO PATIENT: (plan = Charity Pending)

I have received an application today and have been informed I have up to 90 days to complete and return it to Touchette Regional Hospital in order to be considered for financial assistance

Patient (or Applicant) Signature _____ Date _____

APPLICATION REFUSED BY PATIENT: **(**plan = Self Pay**)**

I do not want an application at this time. I have been informed I have up to 90 days to complete an application and may request one by contacting Touchette Regional Hospital within 60 days of my visit.

Patient (or Applicant) Signature _____ Date _____

PATIENT REFUSED TO SIGN: (plan = Self Pay)

The patient was offered a financial application, but refused to accept it and will not sign a receipt of one at this time. The patient has been informed he/she may request one within 90 days of today.

Registrar's Name _____ Date _____

Touchette Regional Hospital

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HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Instructions: Complete all shaded areas on application. If it doesn't apply to you, please enter "N/A".

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)*

-- Temporary Assistance for Needy Families (TANF)
-- WIC
-- Illinois Free Lunch & Breakfast Program
-- Supplemental Nutrition Assistance Program (SNAP)
-- 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

Income Section:

Employer's Name and City:	
Spouse's Employer's Name and City:	

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.)

If you are not employed, how are you meeting your living expenses? **THIS MUST BE COMPLETED IF NO INCOME IS LISTED**

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 _____

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

Touchette Regional Hospital
PO Box 185
East St Louis, IL 62202

PatientAccounting@touchette.org

Fax: (618) 482-7009