

St. Mary's Good Samaritan

Incorporated

If you wish to apply for financial assistance, please complete and return the attached application within **ten (10) days**. Eligibility for assistance is based on family size, income and expenses. Services not eligible for financial assistance include, but are not limited to, medically unnecessary services and services generally not covered by 3rd party payers.

To apply for assistance, simply complete the application and return it to us with documented proof of income for the last three (3) months **and** a copy of last year's tax forms.

If you are potentially eligible for Medicaid, we must have a copy of your approval or denial from Illinois Department of Public Aid. Our Financial Counselor can tell you if your circumstances require a Medicaid determination of eligibility.

We must have this documentation before we can begin processing your financial assistance application. Please take time to check that the following items are enclosed.

- Last year's tax forms (all pages of Federal IRS Form 1040 complete with schedules).**
- Last 3 months "Proof of Income". Check stubs or a statement from the employer are acceptable means of support.**
- Illinois Department of Public Aid Denial / Approval / Spend-down. If applicable, we need proof the account has been applied to the Spend-down.**
- KidCare Denial / Approval if applicable. For more information, please call our office.**

Completion of the application signifies all information provided is true and accurate. Further, the applicant will take any action reasonably necessary to obtain assistance from any program available for payment (Medicaid, Medicare, Insurance, etc.) and will assign or pay to the hospital any amount recovered for hospital charges. If any information given proves to be untrue, it is understood that the hospital may re-evaluate the applicant's financial status and take whatever action becomes appropriate.

Once your application has been reviewed, you will be notified in writing of the determination. Please retain that letter for your records. If you should have questions, please feel free to contact the Patient Accounts Office at (866) 203-5846 or (618) 241-2235.

For processing, please return complete application to:

St. Mary's Good Samaritan, Inc.
605 North 12th
Mt. Vernon, IL 62864

Sincerely,

Financial Counselor

ST. MARY'S GOOD SAMARITAN, INC.

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA

St. Mary's Good Samaritan, Inc., as part of its charitable mission and healing ministry, provides a reasonable amount of its services without charge or at a reduced charge to eligible persons who cannot afford to pay for health care. Financial assistance with your health care is limited to those services provided by St. Mary's Good Samaritan, Inc. Services not eligible for financial assistance include, but are not limited to, medically unnecessary services and services generally not covered by 3rd party payors.

The amount of financial assistance for which you are eligible is based upon the following poverty guidelines issued by the Department of Health and Human Services. They may be found in the Federal Register with effective date February 1, 2011. St. Mary's Good Samaritan, Inc., will provide care without charge to anyone who's family income is less than 2 times the poverty guideline, if the required financial documentation is presented in a timely manner.

<u>Size of Family</u>	<u>Poverty Guideline</u>	<u>Without Charge Guideline</u>
1	\$10,890	\$21,780
2	\$14,710	\$29,420
3	\$18,530	\$37,060
4	\$22,350	\$44,700
5	\$26,170	\$52,340
6	\$29,990	\$59,980
7	\$33,810	\$67,620
8	\$37,630	\$75,260
for each additional family member, add	\$3,820	\$ 7,640

If your income exceeds these financial guidelines and you believe you are unable to pay your account or have unusual or extenuating circumstances, please submit a completed application with necessary documentation and your eligibility will be reviewed.

If you think you may be eligible for financial assistance with your hospital bill, please inform Patient Accounts at St. Mary's Good Samaritan, Inc. A written conditional or final determination of your eligibility for uncompensated services will be made as soon as possible.

If you are potentially eligible for Medicaid, we must have a copy of your approval or denial from Illinois Department of Public Aid. Our Financial Counselor can tell you if your circumstances require a Medicaid determination of eligibility.

Please check the appropriate service provider(s):

- St. Mary's Hospital, Centralia Good Samaritan Regional Health Center, Mt. Vernon SMGS Medical Group

Application for Financial Assistance

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Marital Status: Single / Married / Widowed / Divorced Please check if you are: Disabled Blind

Employer: _____ Date of Hire: _____ Occupation: _____ Hours per Week: _____

What was the last year you filed tax return?: _____ Last Date Worked: _____

LIST & DESCRIBE SOURCES OF INCOME:

(from employment, social security, pension, w/c, unemployment, disability, child support). If NONE, please explain.

Approximate Gross
Income per Month

Family
Size

SOURCE: _____

SOURCE: _____

SOURCE: _____

Have you applied for a Medical Card? Yes No If yes, when? _____

MONTHLY EXPENSES:

ASSETS:

Rent/House Payment _____

Cash on Hand: _____

Gas _____

*Savings Balance: _____

Electric _____

Checking Balance: _____

Water & Sewer _____

Real Estate: _____

Telephone _____

Purchase Price: _____

Food _____

Balance Due: _____

Gasoline/Transportation _____

Car(s):

Clothing _____

Year: _____ Make: _____

Medication _____

Year: _____ Make: _____

Insurance Premiums: _____

House: _____

Monthly Loan Payments:

Auto: _____

\$ _____/mo Bal. due: _____ For: _____

Other: _____

\$ _____/mo Bal. due: _____ For: _____

Additional information which will help us process this application may be listed on the reverse side of this form.

*Savings Balance includes all bank savings accounts, health savings accounts, health reimbursement accounts, medical savings accounts or flexible savings accounts.

I affirm that the above information is true and correct to the best of my knowledge. I also understand that the information is subject to verification and if it is determined to be false, assistance will be denied.

_____ Date

_____ Applicant's Signature