



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.

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 (Federal IRS form 1040).**
- 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 of the determination. If you should have questions, please feel free to contact the Patient Accounts Office at (866) 203-5846, Extension _____.

Sincerely,

Financial Counselor

St. Mary's Good Samaritan, Inc.
400 North Pleasant
Centralia, IL 62801

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

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.

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, 2008. 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	\$10,400	\$20,800
2	\$14,000	\$28,000
3	\$17,600	\$35,200
4	\$21,200	\$42,400
5	\$24,800	\$49,600
6	\$28,400	\$56,800
7	\$32,000	\$64,000
8	\$35,600	\$71,200
for each additional family member, add	\$3,600	\$ 7,200

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.

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
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SOURCE: _____	_____	
SOURCE: _____	_____	
SOURCE: _____	_____	

MONTHLY EXPENSES:

Rent/House Payment _____

Gas _____

Electric _____

Water & Sewer _____

Telephone _____

Food _____

Gasoline/Transportation _____

Clothing _____

Medication _____

Insurance Premiums: _____

House: _____

Auto: _____

Other: _____

ASSETS:

Cash on Hand: _____

*Savings Balance: _____

Checking Balance: _____

Real Estate: _____

Purchase Price: _____

Balance Due: _____

Car(s): _____

Year: _____ Make: _____

Year: _____ Make: _____

Monthly Loan Payments:

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

\$ _____/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