

Carlinville Area Hospital Financial Assistance/Uninsured/Billing

The mission of Carlinville Area Hospital Association is to maintain a professional medical community, a primary care hospital and other health care services, in order to provide acute and preventative health care for the benefit of those persons living in our service area. In order to continue this mission it is imperative that payment be received for services rendered.

As a courtesy to our patients and their families, Carlinville Area Hospital submits claims to any insurance company according to the following guidelines. It is important to present accurate and complete personal and insurance information at the time of registration. Accurate information at the time of registration will minimize billing costs and expedite timely payment for complete resolution of your account. We ask for your assistance in paying your portion of emergency room, outpatient, and inpatient charges at the time of service. Accepted forms of payment include cash, check, debit card, Master Card, Visa & Discover.

Carlinville Area Hospital is a charitable institution that offers assistance to those who qualify. Eligibility will be based on your financial status in comparison with the U.S. Department of Health and Human Services Poverty Guidelines. For qualifications and requirements please contact our Credit and Collections Department.

An itemized statement of your account may be requested at any time by mail or telephone. For concerns, questions, a dispute on your account, or if you need assistance with payment arrangements, a patient representative is available to assist you by calling (217) 854-3141, ext 356 or (800) 828-9923. Please be prepared to provide Patient Name, Patient Date of Birth, Account Number, and Date of Service with your request. If you are leaving a message, be sure to include the best time to reach you.

Carlinville Area Hospital's Business Office Representatives are available Monday through Friday from 8:00 a.m. to 4:30 p.m., excluding holidays.

Carlinville Area Hospital will follow up on any phone requests as quickly as possible, but no longer than two business days following the request. If the request for information was written, the hospital will respond within 10 business days of receipt of the patient request.

**CARLINVILLE AREA HOSPITAL
FINANCIAL ASSISTANCE PROGRAM**

Patient Name: _____ Date of Service: _____

Dear Patient/Guarantor:

On your behalf, your outstanding account(s) with Carlinville Area Hospital may be eligible for possible financial assistance through our Charity Care Program. Eligibility for assistance will be based on your financial status in comparison with the U.S. Department of Health and Human Services Poverty Guidelines.

The items below are needed to aid Carlinville Area Hospital in the evaluation of your account(s) and the financial assistance program.

VERIFICATION OF INCOME

To determine eligibility, income must be verified by using, but is not limited to, the following information with the attached form:

- 1. Paycheck stubs for a period of two (2) consecutive months and/or statements of monthly benefits from Social Security.
- 2. Copies of completed **federal** income tax returns for previous calendar year. If unavailable, a statement (1099 benefit statement) of earnings from the Social Security Office will be accepted in lieu of the federal income tax return.
- 3. Copies of most recent three concurrent checking and savings statements.
- 4. Other information requested by Carlinville Area Hospital for further verification of your financial status.
- 5. Copies of outstanding medical bills for catastrophic situations.
- 6. Completed financial assistance application.

Failure to meet the above criteria provides grounds for denial of financial assistance. Providing false information or excluding requested information may result in denial of financial assistance.

If you are currently unemployed, please include the date you were last employed, why you left, and the date you plan on returning to work.

If you need help or more information, please call (217) 854-3856 or (800) 828-9923, ext. 356.

You are required to provide this information within fifteen (15) working days to ensure that your application for eligibility is fully considered.

MUST RETURN BY: _____

Carlinville Area Hospital Financial Assistance Application

Accounts Receivable Information

Patient Name: _____ Account Number: _____
Balance Due: _____

Patient/Family Information

Resp Party Name: _____ Social Security: _____
Address: _____ Phone or Cell: _____
Employer: _____ Address: _____
Phone: _____
Spouse Employer: _____ Address: _____
Phone: _____
Numbers of Members in Family: _____

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If dependent child is over 18 must provide proof of dependency.

Income Sources – Verification Required

Do not leave this section blank. If an item does not apply, indicate so with a zero or N/A.

Gross Wages – Resp Party: _____	Gross Wages – Spouse: _____
Self Employment: _____	Public Assist/Welfare: _____
Social Security: _____	Work Comp/Unemployment _____
Alimony/Child Support: _____	Pensions: _____
Dividends/Interest: _____	Rents/Royalties: _____
Estates/Trusts: _____	Other: _____
	Total Gross Income: _____

Income sources must be verifiable. Acceptable sources include income tax returns, 1099 benefit statements, copies of W2's, copies of bank statements. If you are currently unemployed, please include the date you were last employed, why you left, and the date you plan on returning to work.

Asset Sources

Cash: _____	Bank Name/Acct# _____
Savings: _____	Bank Name/Acct# _____
Other property besides Home Dwelling: _____	Value: _____
Stocks _____	Bonds: _____

Certification

I/We hereby certify that I/we are of legal age and that the forgoing statements are true and complete. They are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain your property, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made herein, and to determine my/our credit worthiness, including, but not limited to procuring consumer reports from consumer reporting agencies, and credit information from bank and other financial institutions.

Signature of Applicant _____ Date _____

**Signature of Spouse _____ Date _____
If Applicable**



20733 North Broad Street • Carlinsville, IL 62626
Phone (217) 854-3141 • www.cahcare.com

Dear Patient,

Carlinsville Area Hospital is a charitable institution and makes every effort to work with the patients who are unable to meet their financial obligation for services rendered.

In order for the hospital to stay in compliance with our charity policy, we require that you provide us with a copy of your most recent tax return. **If you did not file taxes due to lack of income or employment, please sign below.** Your signature is needed for our records.

I appreciate your cooperation and ask that you sign and return this letter to Carlinsville Area Hospital along with all the information requested on our charity application.

If you have any questions please don't hesitate to call me at (217)854-3856.

Patient's Signature

Date

Patient's Signature

Date

Please check the box below that applies to your situation.

_____ Yes, I have a checking and/or savings account and I have enclosed a copy of my most recent bank statement(s).

_____ No, I do not have a checking or savings account.

Sincerely,

Mary LeGrand
Carlinsville Area Hospital
Credit / Collections