Carlinville Area Hospital & Clinics
20733 N Broad Street Carlinville,
IL 62626

APPLICATION FOR FINANCIAL ASSISTANCE

For Carlinville Area Hospital & Clinics to process your application, all sections must be completed. Along with your application, required documents may include:

- Proof of income for all income sources (previous year's tax return, last two months pay stubs, social security benefit letters, etc.)
- Bank statements (last two months)

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information.

Applicant Name: _____ Social Security #: _____
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State:____ Zip Code:_____

Phone Number: _____ Email: _____

(The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.)

Race: _____ Ethnicity: _____

Sex: _____ Preferred Language: _____

SECTION TWO: HOUSEHOLD MEMBERS and INCOME INFORMATION

Please provide the below information for all immediate family members who live in your home. For application purposes, Family is defined as the applicant, the applicant's spouse, and all of the applicant's children under 18 (natural or adoptive) who live in the applicant's home.

Name	Date of Birth	Relationship to Applicant	Total Gross Monthly Income (All Sources)
(Applicant)		self	

If there is no income, please explain how applicant is supporting themself: _____

_____

_____

Was your service related to a Worker's Compensation claim or motor vehicle accident? Yes / No

SECTION THREE: ASSETS INFORMATION

Please provide any income and assets that members of your household receive.

Asset Type	Current Balance/Value – Applicant	Current Balance/Value – Spouse/Other
Bank Account - Savings		
Bank Account - Checking		
Health Savings Accounts		
Non-Primary Residence Real Estate		

SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Insurance Company Name: _____ Insurance Phone Number: _____

Group Number:_____ Member ID Number: _____

I certify that the above information is true and accurate to the best of my knowledge. I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, Insurance, etc.) to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance. I understand that this application is made so that the hospital can see if I am eligible for financial assistance based upon defined criteria.

Signature of Applicant:_____ Date:_____

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General – (877) 305-5145.
https://www.illinoisattorneygeneral.gov/consumers/healthcare.html