

Application for Community Assistance

PLEASE READ FIRST

Important: ***YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:*** Completing this application will help Marianjoy Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a social security number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Marianjoy will use the information you provide to determine if you are eligible for coverage through a number of community programs. Therefore, it is important that you fill out this application as fully and as accurately as possible. These programs may include:

- Medicare and/or Medicaid
- Subsidies on the Health Insurance Exchange
- Special purpose funds or grants for underserved patients
- Community-based program eligibility

Presumptive Eligibility

The Fair Billing Act defines “presumptive eligibility” as eligibility for hospital financial assistance determined by reference to criteria demonstrating financial need on the part of the patient, and “presumptive eligibility criteria” as the categories identified as demonstrating financial need on the part of a patient used by the hospital in the implementation of presumptive eligibility.

Patients demonstrating one or more of the following will automatically fall under presumptive eligibility:

- Homelessness
- Deceased with no estate
- Mental incapacitation with no representative
- Medicaid eligible but not on the date-of-service or for non-covered services
- Enrollment in a program for low-income individuals with eligibility criteria < 200% [Federal Poverty Level](#) such as:
 - IC, SNAP, Illinois Free Breakfast/Lunch, Low-Income Home Energy Assistance Program, or a community-based medical assistance program with low-income criteria; or receives grant assistance for medical services

Please complete this form and submit it to the hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Marianjoy Rehabilitation Hospital Phone: 630.909.7370 Fax: 630.909.7371 Email: mjmrhassistance@NM.org	Rehabilitation Medicine Clinic Phone: 630.909.7350 Fax: 630.909.7351 Email: rmcassistance@NM.org
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Marianjoy Rehabilitation Hospital



COMMUNITY CARE FINANCIAL APPLICATION

Date _____ Account Number(s) _____ Patient Name _____

Date of Birth _____ Hospital _____ Email Address _____

Patient Address: _____

Primary Contact#: _____ SSN (Optional): _____

Marital Status: ___ single ___ married ___ widowed ___ divorced ___ separated

Spouse Name: _____ Number of persons in patient's family/household _____

Number of dependents: _____ Age of dependents: _____

Patient Status (check all that apply) : Homeless ___ Mental incapacitation ___ Medicaid eligible ___

Deceased with no estate ___ Resident of Illinois ___ Accident or crime victim ___

Are you enrolled in any of the following programs: Woman, Infants and Children Nutrition Program (WIC) ____, Supplemental Assistance Program (SNAP) ____, Illinois Free Lunch and Breakfast Program ____, Low-Income Home Energy Assistance Program (LIHEAP) ____, An organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria ____, Grant assistance for medical services _____.

PLEASE READ CAREFULLY! In order for us to process your application for assistance, proof of income and residency must be attached in order to assess eligibility in government programs. **Please note:** any blank spaces may disqualify or delay processing of your application. **Complete this form in ink.**

Please attach the following requirements:

Pay stub Latest tax return _____ Government grant check Picture I.D.

Copy of utility bill Property tax bill (if home owner) Mortgage statement (if home owner)

For questions, call _____ at _____ Return by _____

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED!):

Are you presently employed? Yes No Are you self-employed? Yes No

Marianjoy Rehabilitation Hospital



Patient or Parent (Only if patient under 18 yrs of age) Spouse or Parent (Only if under 18 yrs old)

Present or Last Employer	
Street Address	Telephone #
City	State Zip
Monthly net income	Monthly net income
Employment Dates From: _____ To: _____ (Previous employment information required if employment is/was short-term.)	Employment Dates From: _____ To: _____ (Previous employment information required if employment is/was short-term.)

**IF HOUSEHOLD INCOME IS AT OR BELOW THE [FEDERAL POVERTY LEVEL](#),
YOU MAY NOT NEED TO COMPLETE THE REST OF THE APPLICATION**

OTHER SOURCES OF INCOME (check type and list amount):

- | | |
|--|---|
| <input type="checkbox"/> Alimony / Child Support _____ | <input type="checkbox"/> Pension Annuity _____ |
| <input type="checkbox"/> Social Security _____ | <input type="checkbox"/> Workmen's Compensation _____ |
| <input type="checkbox"/> Veterans Pension _____ | <input type="checkbox"/> Rental Income _____ |
| <input type="checkbox"/> Unemployment Compensation _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> School Grants _____ | |

Home Owner

Other Property

Location:	Location:
Assessed taxable value:	Assessed taxable value:
Mortgage due:	Mortgage due:

CAR INFORMATION

Make and Year	Model	Lien Holder (if other than applicant)	Value	Loan Balance	Monthly Payment

APPLICANT ASSET DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Checking				
Savings				
Cash on Hand				
Income Property				

APPLICANT LIABILITIES DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Mortgage				
Car Loan				
Credit Cards				
Other				

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I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I WILL APPLY FOR ANY STATE, FEDERAL OR LOCAL ASSISTANCE FOR WHICH I MAY BE ELIGIBLE TO HELP PAY FOR THIS HOSPITAL BILL. I UNDERSTAND THAT THE INFORMATION PROVIDED MAY BE VERIFIED BY THE HOSPITAL, AND I AUTHORIZE THE HOSPITAL TO CONTACT THIRD PARTIES TO VERIFY THE ACCURACY OF THE INFORMATION PROVIDED IN THIS APPLICATION. I UNDERSTAND THAT IF I KNOWINGLY PROVIDE UNTRUE INFORMATION IN THIS APPLICATION, I WILL BE INELIGIBLE FOR FINANCIAL ASSISTANCE, ANY FINANCIAL ASSISTANCE GRANTED TO ME MAY BE REVERSED AND I WILL BE RESPONSIBLE FOR THE PAYMENT OF THE HOSPITAL OR PHYSICIAN BILL.

I authorize the release of information to Marianjoy, Inc. for verification of employment, financial and other information contained herein. Also, I acknowledge that I have made a good faith effort to provide all information requested in the application to assist the hospital in determining whether I/the patient is eligible for financial assistance.

Signature of Patient / Guarantor / Spouse

Date

Admissions/PFS Representative

Date

OFFICE USE ONLY

Recommendations: _____

Monthly Payment: \$ _____ First Payment Due: _____

Approved Declined

Comments _____ Date _____

Director Signature

V.P. Signature