

APPLICATION FOR FINANCIAL ASSISTANCE – INSTRUCTIONS

These instructions will help you prepare your Application for Financial Assistance and assist Memorial in determining eligibility. Please send us the documentation listed below that pertains to you and your household and attach it to the fully completed application.

After your application is complete and copies of documents are prepared:

- Mail completed application, release for information and copies of required documentation to the address below.
- Memorial's Financial Counselor will review and verify the information on your application.
- You may be required to apply for governmental programs (Medicare, Medicaid, Unemployment, etc.) before approval can be granted.
- If approved for financial assistance, your account will be adjusted with the appropriate discount.
- You will be notified by mail of approval or denial within 15 business days after review of a completed application.
- You will be required to reapply for Financial Assistance for services provided more than six months after approval of the application.

Review options below and attach copies of documentation on all that pertains to you and any member of your household.

Send a copy of:

- Federal 1040 or other tax return for the most recent completed tax year.

If taxes were not filed, please send copies of documentation which show any and all sources of income:

- A copy of the W-2 Wage and Tax Statements for most recent calendar year
- A copy of the most recent checking and savings bank statements (please remove or blacken out any account numbers) with a description of all deposits
- A copy of the unemployment compensation statement
- Copies of any other statements which documents sources of income: child support, pension, annuities, and/or any other assets or income.

If the above documents are not available:

- Provide a letter that explains your current financial situation and lists any methods of financial support (friends, family, etc.).

If you have any questions regarding the application process, please contact our Financial Counselor directly at **(618) 257-5530**.

Mail or fax your completed application and copies of applicable supporting documentation to:

MEMORIAL HOSPITAL
Patient Access & Financial Services Department
4500 Memorial Drive
Belleville, IL 62226
Fax: 618-257-6931

APPLICATION FOR FINANCIAL ASSISTANCE

Name(s) of patients that you wish to be considered by this application:

NAME	HOSPITAL ACCOUNT NUMBER(s)	RELATIONSHIP TO APPLICANT
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People currently living in your household:

NAME	RELATIONSHIP	AGE
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GROSS INCOME (for each household member):

Amount of income/wages:

(Per week/month)

Source of Income:

(Employer Name, Unemployment, Child support,
Social Security, Retirement, etc.)

Patient: _____

Spouse: _____

Other – Name: _____

Other – Name: _____

Please use the reverse side of this page to list any additional information.

Attestation:

I represent that the information provided in this application is true, accurate, and complete. I understand that Memorial is relying on this information in determining whether to extend financial assistance and Memorial may rescind financial assistance if the application contains any misrepresentations or omissions. I also further agree to notify Memorial immediately of any changes in the information provided.

Signature

Date