



Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application shall help Midwest Medical Center determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

Patient must apply for Medicaid first if patient does not currently have insurance. Please go to www.abe.illinois.gov or call 1-800-843-6154 to file for Medicaid.

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 shall help Midwest Medical Center determine whether you qualify for any public programs.

Please complete this form and submit it to Midwest Medical Center in person, by mail or by fax to apply for free or discounted care within 90 days following the date MMC provides the first billing statement to the Patient.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Midwest Medical Center in determining whether the patient is eligible for financial assistance.

Required Documents Check List (Please note if you do NOT have any of these forms):

- Most recently filed federal income tax return or most recent W-2 and 1099 form
- Copies of the 2 most recent pay stubs;
- Most recent statement/check voucher for all other income benefits including:
 - Social Security
 - Unemployment/Severance Pay
 - Pension/Retirement
 - Alimony and Child Support
 - Interest/Dividend
 - Disability
 - VA
 - Work Comp
 - Trust
 - Rental
 - Other
- 2 most recent Bank statements – checking and savings
- If self-employed, your 2 most recent business account Bank Statements; most recently filed business tax return including all Schedules; Business Income Statement; and Accounts Receivable Ledger

- Forms approving or denying Unemployment compensation or Workers' Compensation

Notification:

A letter shall be mailed to the Applicant within 30 days after Midwest Medical Center receives the Financial Assistance Application. If information or documents are missing from the Application, the letter shall identify what is missing and what MMC needs to process the Application. If the Application is complete, the letter shall identify financial assistance granted, request a payment plan on any balance due, and a billing statement shall follow showing the balance due.

Certification:

I certify that the information in this Application is true and correct to the best of my knowledge. I shall 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 Midwest Medical Center, and I authorize Midwest Medical Center 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 shall be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I shall be responsible for the payment of the hospital bill.

Date of Request:_____ Patient or Applicant's Signature:_____

Once form is complete, please return via mail, fax or in person.

Mail:

Midwest Medical Center
Attention: Patient Account Specialist
One Medical Center Dr.
Galena, IL 61036

Fax: 815-776-7274

In Person: Drop off at any registration desk at the hospital and/or clinic

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security#: _____ - _____ - _____

Street Address _____

City _____ State _____ Zip _____

Phone: _____ E-mail Address: _____

Employer: _____ Employer's Phone Number: _____

Employer's Address: _____

Single Married Civil Union Divorced Widowed

Spouse/Partner/Parent/Guardian Name: _____

Street Address _____

City _____ State _____ Zip _____

Phone: _____

Employer: _____ Employer's Phone Number: _____

Employer's Address: _____

of Persons in the Patient's Family/Household: _____

of Persons who are Dependents of the Patient: _____ Ages of Patient's Dependents: _____

Monthly Household Income

Source	Patient Amount/Frequency	Spouse/Partner/Parent/Guardian Amount/Frequency
Wages	\$ _____ / _____	\$ _____ / _____
Unemployment	\$ _____ / _____	\$ _____ / _____
Work Comp	\$ _____ / _____	\$ _____ / _____
SS/SSI/SSD	\$ _____ / _____	\$ _____ / _____
Child Support/Alimony	\$ _____ / _____	\$ _____ / _____
VA Benefits	\$ _____ / _____	\$ _____ / _____
Private Disability	\$ _____ / _____	\$ _____ / _____
Pension/Retirement	\$ _____ / _____	\$ _____ / _____
Interest/Dividend	\$ _____ / _____	\$ _____ / _____
Trust	\$ _____ / _____	\$ _____ / _____
Rental	\$ _____ / _____	\$ _____ / _____
Other Income	\$ _____ / _____	\$ _____ / _____

Assets: Please identify your assets and estimated asset value

Financial Accounts	Name of Financial Institution/Administrator	Estimated Value
Checking Account		
Savings Account		
Certificates of Deposit		
Health Savings/Flex Spend		
Investments	Name of Stock/Fund	Estimated Value
Stocks		
Mutual Funds		
Vehicles	Year Make and Model	Estimated Value
Automobile		
Automobile		
Other		
Real Property	Address	Estimate Value

Monthly Household Expenses

Rent/Mortgage _____	Gas/Electric _____	Food _____
Telephone _____	Water/Sewer _____	Child Care _____
Transportation _____	Medical _____	Loans _____
Description of other expenses and dollar amount _____		

