

To learn more about SIH Healthcare Assistance Program, obtain a free copy of the HAP application, policy, and plain language summary, or obtain assistance with the HAP application process, please speak with a Financial Counselor Monday – Friday from 8:00 am to 4:30 pm at any of the following locations:

Memorial Hospital of Carbondale

405 W Jackson
Carbondale, IL 62902
Phone 618.549.0721
ext. 64572
Fax 618-351-6540

Herrin Hospital

201 S 14th Street
Herrin, IL 62948
Phone 618.942.2171
ext. 36458
Fax 618-351-6540

St. Joseph Memorial Hospital

2 S Hospital Drive
Murphysboro, IL 62966
Phone 618.684.3156
ext. 55331
Fax 618-351-6540

Harrisburg Medical Center

100 Dr. Warren Tuttle Dr
Harrisburg, IL 62946
Phone 618.253.0251
Fax 618-253-0475

HMC Clinic at Marion

3106 Outer Dr.
Marion, IL 62959
Phone 618.253.0251

Eldorado Primary Care

1007 US Hwy 45 North
Eldorado, IL 62930
Phone 618.253.0251

Confidential appointments and language translation services are available upon request.

A free copy of the HAP application, policy, and plain language summary is available online at sih.net/hap

You may also obtain information by sending a written request to any of the addresses listed in the brochure.

Please be sure to add
Attention: Financial Counselor

HAP application, policy, and plain language summary are available in English, Spanish and Arabic.

SIH adheres to its values of respect, integrity, compassion, accountability, collaboration, stewardship and quality.

Our Mission

We are dedicated to improving the health and well-being of all of the people in the communities we serve.

sih.net



Healthcare Assistance Program

Help with your hospital bill



Healthcare Assistance Program

SIH's Healthcare Assistance Program (HAP) is designed to help patients who cannot pay their hospital bill. HAP applies to emergency and other medically necessary care provided by SIH hospitals, as well as for certain providers delivering care in SIH facilities.

To receive assistance, generally patients must complete and submit a HAP application and provide supporting documentation. Certain circumstances may not require an application.

SIH provides free care to all patients whose income is less than or equal to 200% of the Federal Poverty Guidelines, and partial assistance based on a sliding scale for those patients whose income is up to 600% of the Federal Poverty Guidelines.

No one eligible for financial assistance under the HAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. Please refer to the full HAP policy for complete details on available assistance.

The Healthcare Assistance Program is widely available to all patients. Applications are processed regardless of age, race, ethnicity, religion, gender, gender identity, and/or sexual orientation.

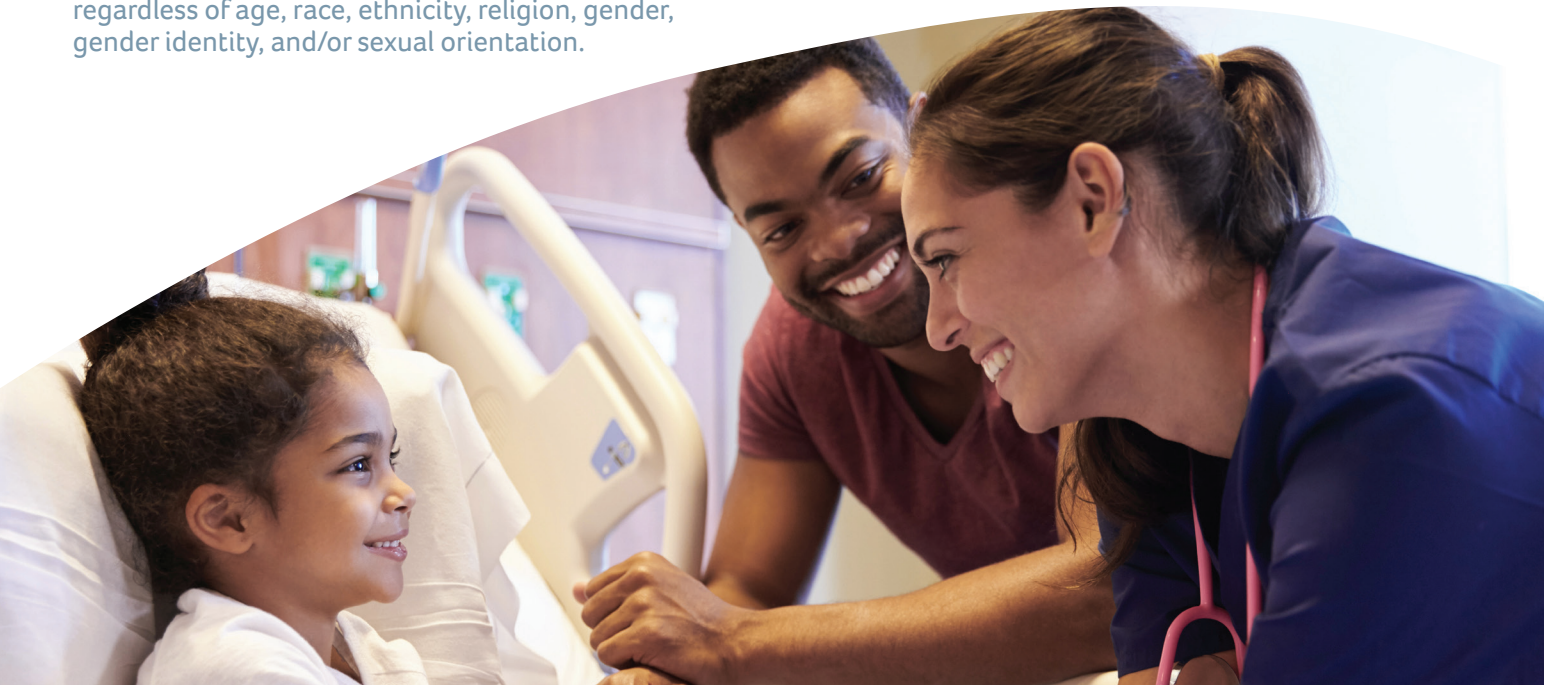
Uninsured patients are given the opportunity to be screened for public health insurance programs and/or the Healthcare Assistance Program.

Complaints concerning the uninsured patient discount applied or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at illinoisattorneygeneral.gov/consumers/hcform.pdf or by calling 1-877-305-5145.

MyChart

SIH offers a convenient on-line option, available 24/7, to apply for the Healthcare Assistance Program. The application and complete instructions can be found by simply logging in to mychart.sih.net and choosing Billing and Financial Assistance.

“SIH provides the same quality care to all people seeking medical services regardless of their ability to pay.”





Harrisburg Medical Center
100 Dr Warren Tuttle Dr
Harrisburg IL 62946
(618) 253-0251
Fax (618) 253-0475

Dear Patient/Guarantor:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help _____, 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.

Please complete this form and submit it to the hospital in person, by mail, by fax (618)253-0475 or by email HMC_Patient_Accounts@sih.net to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care.

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

Please understand in order to receive assistance with your hospital bill you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. All payors must be fully exhausted before healthcare assistance will be considered.

Certain circumstances in which a patient may be eligible for presumptive eligibility may not require an application. Please contact a Financial Counselor at the number above to learn more.

Please return the application with the following information:

1. A complete Healthcare Assistance Program application signed and dated.
2. A copy of your last federal tax return filed. If self-employed you must include Schedule C. Please include a copy of all W2's.
3. A copy of your most recent check or check stub for employment, unemployment, Social Security, pension, workmen's compensation (or work comp determination letter) or any other source(s) of income you have received for the past thirteen (13) weeks. We will accept one of the following three documents for proof of wages:
 - a. An employee wage form filled out and signed by your employers for each wage earner in the household. (see application for this form).
 - b. Copies of check stubs for the last 13 weeks.
 - c. A printout of your wages from your employer for the last 13 weeks.
 - d. The above wage information must be approved for all family/household members.
4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Link, school lunches, Child Care Resource or Referral Program.
5. You may be asked to apply for assistance from other appropriate sources if it is determined you could qualify for such aid.

If you want to submit an appeal of our decision or request re-consideration it must be in writing. Please include the reason or provide additional information that may be beneficial for our review.

Complaints or concern 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 at www.illinoisattorneygeneral.gov/consumers/hcform.pdf or 1-877-305-5145.

SIH now offers convenient electronic option for completing healthcare assistance applications by logging onto MyChart. Visit www.mychart.sih.net 24/7 for complete instructions. You may also mail the completed application to the address listed for the facility where you incurred charges.

Only one application is required if you have accounts at the hospital listed above. If you need assistance in completing the application, please contact the Financial Counselor at the (618)253-0221. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

Completion of this application does not relieve you of your financial obligation to Harrisburg Medical Center. Harrisburg Medical Center reserves the right to deny any application upon review.

Sincerely,

HMC Financial Counselor



Harrisburg Medical Center
100 Dr Warren Tuttle Dr
Harrisburg IL 62946
(618) 253-0251
Fax (618) 253-0475

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Healthcare Assistance Application

Name: _____ Date of Birth: _____

Address:

Street Address/PO Box City State Zip Code

Phone Number: _____ Social Security Number _____ (not required)

Family/household information:

1. Number of persons in the patient's family/household: _____
2. Number of persons who are dependents of the patient: _____
3. Ages of patient's dependents: _____

Employment and Income Information

1. Enter patient's, patient's spouse or partner's employer information.
2. If patient is a minor, enter the patient's parent's or guardian's employer information.

Patient	Spouse	Partner	Other
Patient's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Spouse's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Partner's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Other Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>
Patient's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Spouse's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Partner's Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>	Other Employer Name: Address: City, State, Zip <hr/> Salary :Gross Amount <hr/>

Other Income

Other Income	Patient's Monthly Income	Spouse/Partner/Other Dependent's Monthly Income
Wages	\$	\$
Self -Employment	\$	\$
Unemployment Compensation	\$	\$
Social Security	\$	\$
Social Security Disability	\$	\$
Veteran's Pension/Disability	\$	\$
Workers' Compensation	\$	\$
Temporary Assistance for Needy Families	\$	\$
Retirement Income	\$	\$
Child Support, Alimony or Other Spousal Support	\$	\$
Other Income	\$	\$

Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

***Assets**

Real Estate: Own ____ Rent ____		Bank: Checking	\$
Market Value	\$	Savings	\$
Amount Owed:	\$		
	\$	Mutual Funds:	\$
Auto/Truck/Type:		Stocks, CD's:	\$
Market Value:	\$	Rental Property Owned:	\$
Motorcycles, Boats, Campers, Other Vehicles:		Other:	\$
Market Value	\$		\$
			\$
			\$

*Assets are not required for National Health Services Corps (NHSC) Location at HMC Clinic at Marion or Eldorado Primary Care

Monthly Expenses

Rent or House Payments:	\$	Other:	\$
Utilities	\$		\$
	\$		\$
	\$		\$
	\$		\$
Child Care:	\$		\$
Food and Supplies:	\$		\$
Auto Payments:	\$		\$
Transportation	\$		\$
Credit Cards:	\$		\$
Property Tax: (Annual) :	\$		\$
		Total Monthly Expenses	

I certify that the information in this application is true and correct to the best of my knowledge. 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 bill.

Y
N

Was the patient an Illinois resident or temporary resident when care rendered?

*If temporary resident, please provide copy of temporary visitor's drivers license

Y
N

Was the patient involved in an alleged accident?

Y
N

Was the patient a victim of an alleged crime?

Y
N

Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?

Y
N

Does the applicant (s) have any insurance benefits?

OPTIONAL DEMOGRAPHIC INFORMATION: (circle best option)

***Response or nonresponse will not have any impact on the outcome of this application**

Race

American Indian or Alaska Native

Asian

Asian Indian

Black or African American

Chinese

Native Hawaiian or Other Pacific Islander

Other Race

White

Ethnicity

Hispanic or Latino

Not Hispanic, Latino/a, or Spanish Origin

Sex

Male

Female

Male transitioning to Female

Female transitioning to Male

Preferred Language _____

Complaints or concern 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 at www.illinoisattorneygeneral.gov/consumers/hcform.pdf or 1-877-305-5145.

Date: _____

Signed: _____

Patient/Applicant

Date: _____

Signed: _____

Patient/Applicant

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

2. If your tax return is not included, please explain why.

3. If you have no income how do you support yourself?

4. If you are receiving financial support from anyone, include a written statement how they are helping you.

5. Other:

Employee Wage Form

(To Be Completed And Signed By Employer)

Employee Name: _____

Employee Social Security Number: _____ (not required)

Employer Name: _____ Tele: _____ Ext. _____

Address: _____

City

State

Zip Code

Wages For The Last 13 Weeks

Week	Pay Period Ending	Gross Wages
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____(yes/no), If no, when was the last day worked?

2. If the employee is not currently working, will the employee be returning to work? _____ (yes/no)
Expected return date _____

3. When did employment begin: _____ End: _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____

Signed: _____

Signature of Employer or
Employer's Representative