YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help CGH Medical Center 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 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 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.

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.

For proof of income, we require: (for all people in the household)

- **A copy of your last 3 months of checking and/or savings statements**
- **Your most recent Federal income tax return**
- **If you do not file taxes, or have worked less than 1 year in your current job, please provide:**
  - **a copy of your last 3 months of paystubs**
  - **or a written statement of your last 3 months of pay from your employer.**
- **If retired or on social security or unemployment, please provide a copy of your monthly benefit.**

For college students, if your parents claim you on their taxes their income will be required. College students must be able to show financial independence to be considered for a household of 1.

If unable to supply the necessary documents above, provide a written statement explaining your current situation.

Please return all documents to:
CGH Medical Center
Attn: Brianna Maas
100 E LeFevre Road
Sterling, IL 61081
Phone: 815-564-4618 Fax: 815-564-4932 Email: MyEstimate@cghmc.com

FINANCIAL ASSISTANCE APPLICATION

Name: (Last)_____ (First)_____ (Middle Initial)_____

Date of Birth: _____/_____/_____ Social Security Number:_____
(*Not required if uninsured)*

Home Address: (Street or P.O. Box) _____

(City) _____ (State)_____ (Zip Code)_____

Home/Cell Phone Number: ( ) _____ Cell Phone Number: ( ) _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Significant Other's Name: _____ Significant Other's Date of Birth: _____

Patient's Email Address: _____

Dependent's Name (Other people living in the same house or full time college students)	**Birthdate**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employer's Name:_____ Spouse's Employer:_____

Occupation:_____ Spouse's Occupation:_____

How many years have you worked there?____ How many years have they worked there?____

Employer's City/State_____ Employer's City/State_____

Name of banking institution for checking and savings? _____
Name of banking institution for checking and savings? _____
Please enclose 3 months' worth of bank statements for checking and savings account(s).
Please include all pages to each bank statement.

INCOME

	Yourself—Monthly	Spouse—Monthly
Gross Monthly Wages Amount	$	$
Unemployment Monthly Amount	$	$
Social Security Monthly Amount	$	$
Disability Monthly Amount	$	$
Pension Monthly Amount	$	$
Rental Income	$	$
Alimony Child Support you receive	$	$
Other Monthly Income	$	$

MONTHLY EXPENSES

Rent or House Payment:	Child Care:
Utilities Payment:	Loan Payments:
Food:	Medical Expenses:
Transportation:	Other Expenses:

Certification Statement

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.

Did you remember to include? ☐ **3 Months Bank Statements – Checking and/or Savings**
☐ **Proof of Income (see attached letter for guidelines)**

Date:_____ Signature of Applicant: _____

Signature of Joint Applicant: _____

This discount does not apply to the following items, PLEASE DO NOT COMPLETE AN APPLICATION FOR THESE SERVICES:

- Glasses/Contacts
- Cosmetic Services
- Services considered non-covered by Medicare
- Orthotics
- Hearing Aids
- Routine Dental Care