CGH Medical Center Hospital and Clinics application for free or discounted care

Completing this application will help CGH Medical Center determine if you qualify for free or discounted services. Applications for financial assistance can be completed on-line at www.cghmc.com/charitycare or in paper form by completing the attached application. Emailing pictures of the application and supporting documents is acceptable.

What Information Is Needed?

All applicants:

- Copies of last 3 months of all bank statements

--If working:

- 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 the last 3 months of paystubs

--If not working:

- Most recent Federal income tax return
- Copy of unemployment statement (if applicable)
- Written statement of last date worked, name of company worked for, last hourly wage, weekly number of hours worked
- Statement of current work situation and when expected to work again

--If retired:

- Proof of monthly social security benefit (if applicable)
- Proof of monthly pension benefit (if applicable)

--If in college:

- 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.

How To Return The Application?

By Email: MyEstimate@cghmc.com

By Mail: CGH Medical Center, Attn:Financial Counselor, 100 E. LeFevre Road, Sterling, IL 61081

In Person: CGH Patient Accounts, 1813 2nd Avenue, Sterling, IL

Questions?

Call: 815-564-4618 **Fax:** 815-564-4932

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