Sparta Community Hospital
Patient Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:
Completing this application will help Sparta Community Hospital 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 application and submit within 90 days following date of discharge or receipt of outpatient care to apply for free or discounted care. You may contact Patient Financial Services at 618-443-6821 with questions or concerns regarding the application process. Completed applications can be submitted:

- In person: Suite 5, Broadway Plaza, Sparta, IL 62286
- By mail: Sparta Community Hospital, Attn: Patient Financial Services, P.O. Box 297, Sparta, IL 62286
- By e-mail: PFS@spartahospital.com
- By fax: 618-443-1382

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.

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ E-mail: _____

Patient Social Security Number: _____

Was the patient an Illinois resident when care was rendered? _____Yes _____No
Was the patient involved in an alleged accident? _____Yes _____No
Was the patient a victim of an alleged crime? _____Yes _____No

OPTIONAL: The Illinois Hospital Uninsured Patient Discount Act requires we ask the following; however, completion is optional. Responses or nonresponses will not have any impact on the outcome of the application.

Race: _____White _____Black or African American _____Asian _____Other Race: _____

Ethnicity: _____Non-Hispanic _____Hispanic Sex: _____Male _____Female

Preferred Language: _____

Sparta Community Hospital
Patient Financial Assistance Application

Household Size

Number of persons in the patient's family/household: _____ Number of Dependents: _____

Ages of Dependents covered by this application:
1.) _____Age 2.) _____Age 3.) _____Age 4.) _____Age 5.) _____Age 6.) _____Age

Household Income Calculation

Are you or your spouse/partner currently employed? _____Yes _____No

If yes, please provided name, address, and the telephone number of all employers:

Employer Name	Address	Phone
Employer Name	Address	Phone

If divorced or separated is your former spouse or partner financially responsible for the patient's medical care per the dissolution of separation agreement? _____Yes _____No

Gross monthly family income, including cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is guarantor for a minor from sources, such as:

- Wages
- Self-employment
- Unemployment compensation
- Social Security
- Social Security disability
- Veteran's pension
- Veteran's disability
- Private disability
- Workers' compensation
- Temporary Assistant for Needy Families (TANF)
- Retirement income
- Child support, alimony, or other spousal support
- Other income

Income type: _____ Amount $ _____ Frequency _____

Income type: _____ Amount $ _____ Frequency _____

Income type: _____ Amount $ _____ Frequency _____

Income type: _____ Amount $ _____ Frequency _____

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

Sparta Community Hospital
Patient Financial Assistance Application

Asset Information

Checking: $_____ Savings: $_____
Stocks: $_____ Certificate of Deposit: $_____
Mutual Funds: $_____ Health Savings/Flexible Spending Account: $_____

Automobile & Other Vehicles:
Description: _____ Value $_____
Description: _____ Value $_____

Real Estate (excluding your primary residence): $_____

Maximum Collectible

For a patient qualifying for discounts under the Illinois Hospital Uninsured Patient Discount Act, the maximum amount collectible by the hospital is 20% of the patient's family income during a 12-month period.

Has the patient previously received an uninsured discount from this hospital for services provided within the past 12-months? _____Yes _____No

Certification

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 assistant 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.

Patient or Guarantor Signature: _____ Date: _____

Complaints

Complaints or concerns 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 by calling 1-877-305-5145 (TTY 1-800-964-3013) or visiting https://illinoisattorneygeneral.gov/consumers/hcform.pdf.