This electronic application applies to all the facilities listed below:

Harrisburg Medical Center
100 Dr Warren Tuttle Dr
Harrisburg IL 62946
(618) 253-0251
Fax (618) 351-6540

Memorial Hospital of Carbondale
405 W Jackson
Carbondale IL 62902
(618) 549-0721 ext 64572
Fax (618) 351-6540

Herrin Hospital
201 S 14th Street
Herrin IL 62948
(618) 942-2171 ext 36458
Fax (618) 351-6540

St Joseph Memorial Hospital
2 South Hospital Drive
Murphysboro IL 62966
(618) 684-3156 ext 55331
Fax (618) 351-6540

SIH Medical Group
1239 East Main Street
Carbondale IL 62901
(618) 457-5200 ext 67575
Fax (618) 351-6540

Dear Patient/Guarantor

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Southern Illinois Healthcare, determine If you can receive free or discounted services or other public programs that can help pay for your healthcare. Your completed application can be submitted via MyChart, Fax 618-351-6540, or to the cashiers at any of the facilities listed above.

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 determine whether you qualify for any public programs.

Please understand in order to receive assistance you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. All payers must be fully exhausted before healthcare assistance will be considered. Please complete this form to apply for free or discounted care withing 90 days following the date of discharge or receipt of outpatient care.

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.

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:

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 bill.

I understand that the information provided may be verified, and I authorize Southern Illinois Healthcare to contact third parties to verify the accuracy of the information on 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.

Was the patient an Illinois resident when care was rendered?

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

Yes

No

Was the patient involved in an alleged accident?

Yes

No

Was the patient a victim of an alleged crime?

Yes

No

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

Yes

No

Does the applicant(s) have any insurance benefits OR Medishare/Ministry funded plan?

Yes

No

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.

By signing this document below, I acknowledge and certify that I have read this document and that all the information provided is true and accurate.

Date: Signature:

Patient/Applicant

Date: Signature:

Patient/Applicant