Financial Assistance Application

SIU Medicine & SIU Center of Family Medicine
PO Box 19651, Springfield, Illinois 62794-9651
Phone: 217-545-8000 **Fax**: 844-470-2488 **Email**: patientfinancialassistance@siumed.edu

Responsible Party Information:			
Name (First, Middle, Last)			
Date of Birth:	**Social Security Number:**	**Phone Number**:	**Email address:**
***Race:**	***Ethnicity:**	***** Are you a Veteran? (circle one)** Yes/No	***Living in Public Housing? (circle one)** Yes/No
Home Address (City, State, Zip):			

* Indicates information that is required to be collected by the Federal Government

Members of Household/Dependents (you, your spouse, if you are married, live in partner, and your tax dependents)		
Name	**Data of Birth**	**Relationship**

Presumptive Eligibility:

Does any of the information below apply to the applicant/responsible party? Please check all that apply. Please include documentation/verification if checking YES to any of the following:

- ☐ Homelessness – shelter
- ☐ Deceased with no Estate
- ☐ Medicaid eligibility, but not on date of service or for non-covered services that meet medical necessity
- ☐ Incarceration in penal institution
- ☐ Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
- ☐ Enrolled in Temporary Assistance for Needing Families (TANF)
- ☐ Women, Infants and Children's (WIC) Nutrition Program
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Low Income Home Energy Assistance Program (LIHEAP)

If you have checked any of the boxes above, please sign the application and send the application and the supporting documents to the mailing address, email address or fax number listed above. No need to continue to complete the remaining portion of the application. It can also be submitted at any registration desk at SIU Medicine or SIU Center for Family Medicine location.

Insurance/Liability Coverage:	
Is the applicant or responsible party covered under any insurance policy that would be responsible for your medical bills (Medicare, Medicaid, Veteran's benefits, Employer-paid Policy, Auto Insurance Policy, or Workman's Compensation)? If yes and bills have not been submitted, please provide information:	
Policy Holder Name (First, Middle Initial, Last):	
Insurance Company:	Policy/Claim #:

Employment Information:		
Employer's Name:	Employers Address:	
Member of household employed:	Job Title	Date of Employment:
Hourly Wage/Salary:	Pay Cycle: (check one) ☐ Weekly ☐ Bi Weekly ☐ Twice a Month ☐ Monthly ☐ Annually	
Employer's Name:	Employers Address:	
Member of household employed:	Job Title	
Hourly Wage/Salary:	Pay Cycle: (check one) ☐ Weekly ☐ Bi Weekly ☐ Twice a Month ☐ Monthly ☐ Annually	

Income Information: (complete all that apply)				
Source	**Household member**	**Amount**	**Household member**	**Amount**
Social Security/Disability				
Self-Employment				
Unemployment				
Spousal/Child Support				
Annuities/Dividends/Interest				
Pension Income				
Income from Other Sources				

Asset Information: (complete all that apply)

This includes: cash, checking and savings accounts, health savings accounts (HSA), flexible savings accounts (FSA), stocks, and bonds.

Asset Type	**Household Member**	**Amount**	**Bank/Description**

I understand this information will be used only for determination of financial responsibility for my charges at SIU Medicine and SIU Center for Family Medicine, and will be kept confidential. My signature authorizes SIU Medicine and SIU Center for Family Medicine to verify any information furnished on this form. To the best of my knowledge, the information provided above is true and correct. Should SIU Medicine discover that the information provided is false or incorrect, we reserve the right to reconsider the decision.

Responsible Party/Applicant Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED APPLICATION AND ALL REQUESTED DOCUMENTATION WITHIN 15 DAYS. IF APPROPRIATE DOCUMENTATION IS NOT ATTACHED, THE APPLICATION CANNOT BE PROCESSED AND ADDITIONAL DOCUMENTS REQUESTED.

When sending private health information or financial information via unencrypted email there may be risk of interception or access to the information by a third party. By sending this information to SIU Medicine using unencrypted email, you acknowledge the potential risk of exposure of the content of the email by a third party.