St. Margaret's Health
Patient Accounts Center
SMP Health System

Application for Financial Assistance / Uninsured Discount

221 W. St. Paul Street, Spring Valley, IL 61362
PHONE: (815) 664-1575 FAX: (815) 664-1637 EMAIL: jkneebone@aboutsmh.org

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:
Completing this application will help St. Margaret's Health determine if you can receive free or discounted services or other public programs that can help you pay for your healthcare. Please submit this completed application to St. Margaret's Health.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE 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 St. Margaret's Health determine whether you may qualify for any public programs.

Please complete this form and submit it to St. Margaret's Health 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 St. Margaret's Health in determining whether the patient is eligible for financial assistance.

Guarantor (Responsible party/person)

Name: _____

Birthdate: _____

Social Security Number: _____

Street Address:_____

City/State/Zip: _____

Telephone / Cell Phone: _____

Email: _____

Marital Status: _____

Income

Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ (mo/years) Gross Wages: _____ (weekly, bi-weekly, monthly)

Additional Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ (mo/years) Gross Wages: _____ (weekly, bi-weekly, monthly)

Other Income You Receive *(Mo. Amt.)*

Social Security/Disability Amount ..... $_____

Pension Amount/ Veterans Benefits ..... $_____

Unemployment or Work Comp Amount..... $_____

Alimony Amount/ Child Support ..... $_____

Other Income Amount (Housing allowance, food stamps, interest income, etc.)..... $_____

Explain: _____

Spouse

Name: _____

Birthdate: _____

Social Security Number: _____

Street Address:_____

City/State/Zip: _____

Telephone / Cell Phone: _____

Email: _____

Marital Status: _____

Income

Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ (mo/years) Gross Wages: _____ (weekly, bi-weekly, monthly)

Additional Employer:

Name: _____

City/State/Zip: _____

How long employed: _____ (mo/years) Gross Wages: _____ (weekly, bi-weekly, monthly)

Other Income You Receive *(Mo. Amt.)*

Social Security/Disability Amount ..... $_____

Pension Amount/ Veterans Benefits ..... $_____

Unemployment or Work Comp Amount..... $_____

Alimony Amount/ Child Support ..... $_____

Other Income Amount (Housing allowance, food stamps, interest income, etc. ..... $_____

Explain: _____

Living Arrangements and Assets

Please circle one: OWN RENT NURSING HOME OTHER (please explain): _____

Monthly Mortgage Payment: $_____ Balance: $_____ Estimated Value: $_____

Real Estate in Addition to your Primary Residence _____ ***Est. Value***

Cash on Hand / Checking Account / Savings Account Balance..... ***$***_____

Health Savings Account (HSA) or Flexible Spending Account Balance ..... ***$***_____

Stocks or Bonds / Trust Fund ..... ***$***_____

IRA or CD Accounts..... ***$***_____

Primary Vehicle: Make _____ Year _____ Amt. Owed: _____ ***$***_____

Other Assets: (Additional vehicles, trailer home / RV, campers, boats, motorcycle, etc., or other personal property)

_____ ***$***_____

_____ ***$***_____

Family Size

Dependents residing with you:

Name	**Relationship**	**Age**	**Marital Status**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Citizen/Alien Status**

Alien status will be used solely for purposes of applying for Financial Assistance benefits.

Please check all that apply:

- ☐ U.S. Citizen
- ☐ Patient was Illinois resident at time of service
- ☐ Student / Tourist / Business Traveler with non-immigrant visa
- ☐ Lawful permanent resident (has alien card)
- ☐ Alien with valid current employment authorization card
- ☐ Undocumented

Other

Do you have any outstanding liens or legal cases pending? If yes, please explain: _____

Was patient involved in an alleged accident or victim of an alleged crime? If yes, please explain: _____

_____

Copies of the following forms must be returned with your application (if applicable):

-Public Aid approval or denial letter if uninsured.

-Most recent complete federal income tax return for all adults in household.

-Most recent check stub(s), from all jobs or unemployment benefit information and dates for adults in household.

-Legal document for child support or alimony received or paid.

-Your most recent bank statement(s).

-Benefit letter or document from government or public programs (Such as Social Security, Veterans, Public Aid) listing amount received.

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 assistance for which I may be eligible to help pay this St. Margaret's Health bill. I understand that the information provided may be verified by St. Margaret's Health, and I authorize St. Margaret's Health 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 St. Margaret's Health bills.

Patient or Applicant Signature and Date _____

If a patient meets the presumptive eligibility criteria established in Section 4500.40 under The Fair Patient Billing Act or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information.