Financial Assistance Program (FAP) Summary

Harrisburg Medical Center is committed to serving our community and grants financial assistance, in the form of free or discounted care, to patients who meet the criteria of the Financial Assistance Program. The FAP provides assistance to individuals who are uninsured or under-insured and have medical bills for care billed by Harrisburg Medical Center at the following locations:

- Harrisburg Medical Center, Inc.
- Harrisburg Medical Center Physician billing for hospitalists , emergency room providers, certified registered nurse anesthetists and EKG/stress tests provider billing Mulberry Center
- Mulberry Center
- HMC Orthopaedic Clinic
- HMC Specialty Clinic
- Eldorado Primary Care
- Equality Family Practice
- HMC Clinic at Harrisburg
- HMC Clinic at Marion
- Galatia Primary Care

Individuals meeting the Program criteria may be approved for a full or partial reduction of their hospital bill and will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed to third party payors.

Providers delivering care in the hospital which are not covered by the financial assistance policy are cardiologists, gastroenterologists, pediatric cardiologists, nephrologists, obstetricians and gynecologists, nephrologist, neurologist/sleep medicine, oncologist/hematologist, ophthalmologists, pathologists, podiatrists, psychiatrists, pulmonologists, urologists, radiologists, surgeons not employed by the hospital, and family practice physicians not employed by the hospital. To request listing by provider name contact the Financial Counselor at (618)253-7671 ext. 10251.

To apply for the Financial Assistance Program or to learn more about the Financial Assistance Program:

- Visit our website at www.harrisburgmc.com.
- Visit our Business Office, Monday thru Friday, 8:00 am – 4:30 pm at
  100 Dr. Warren Tuttle Dr.
  Harrisburg IL 62946
- Call a Financial Counselor at (618)253-7671 ext. 10251

Harrisburg Medical Center, Inc. (618)253-0221 ***HMC Clinic at Harrisburg (618)252-0411***
Eldorado Primary Care (618)273-7723 ***HMC Clinic at Marion (618)997-4332***
Equality Family Practice (618)276-5196 ***Galatia Primary Care (618)268-4083***
HMC Orthopaedic Clinic (618)253-0169 ***HMC Specialty Clinic (618)253-0161***

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Harrisburg Medical Center 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 or clinic. **For questions or assistance contact the Financial Counselor at (618)253-7671 ext. 10251, visit Harrisburg Medical Center's Business Office at 100 Dr. Warren Tuttle Dr., Harrisburg IL 62946 or visit our website at www.harrisburgmc.com.**

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 or clinic determine whether you qualify for any public programs.

Please complete this form and submit it and supporting documents listed below to the hospital or clinic 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.

- ✓ Complete Federal & State Income Tax Return (including all schedules)
- ✓ Proof of Income, Applicant & Guarantor (i.e. one month's current pay stubs, unemployment received, pension letter, etc.)
- ✓ Proof of Income, if you are self-employed must provide current year-to-date interim Income Statement
- ✓ No Income Letter (Form Attached)
- ✓ Acceptable Denial from Medicaid or proof of income that you don't qualify.

PART A – PATIENT INFORMATION

_____ _____ _____
Patient's Full Legal Name | Date of Birth | Social Security Number (not required)

_____ _____ _____
Address (Number and Street, State, Zip Code) | Home Phone No | Cell Number

Was the patient an Illinois resident when care was rendered? ( ) Yes ( ) No
Was the patient involved in an alleged accident? ( ) Yes ( ) No If yes, who is the responsible party?_____
Was the patient a victim of an alleged crime? ( ) Yes ( ) No

_____ _____ _____
Occupation | Name of Current Employer | Address/Phone Number of Employer

Did the patient have any of the following coverage(s)s effective on the date of service:

( )Medicare ( )Medicaid ( )Veteran's benefits ( ) Health insurance, list name _____
( ) Supplemental plan, list name _____

PART B – GUARANTOR INFORMATION (i.e. Spouse, Partner, Parent, Guardian)

_____ _____ _____ _____
Full Legal Name (Spouse, Parent, Guardian) | Relationship to Patient | Address | Phone Number

_____ _____ _____
Occupation | Name of Current Employer | Address/Phone Number of Employer

Pg 2. Patient Name:_____

PART C – HOUSEHOLD INFORMATION

List the number of persons in the patient's family/household: _____
List the Ages of Dependents (not including self) that you claimed on your last tax return.

- Ages: _____

PART D – GROSS INCOME
Total Family Income PER MONTH

$_____ Patient/Responsible Party Salary (GROSS)
$_____ Spouse/Parent Salary (GROSS)
$_____ Social Security Benefits
$_____ Pension (including VA pension)
$_____ Disability Benefits
$_____ SSI/TANF
$_____ Alimony received
$_____ Rental Income received
$_____ Business Income
$_____ Unemployment benefits
$_____ Workman's Compensation benefits
$_____ General Assistance
$_____ Other (Please explain)

$_____ TOTAL MONTHLY INCOME

PART E – SPECIAL SITUATIONS *** If you did not file a tax return last year please indicate the reason below and the last year you did file a return.*******

_____
_____
_____
_____
_____
_____

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.

_____ _____
Signature of Patient/Responsible Party Date
Implement 2/20/06, Revised 03/18/13, 3/25/14, 3/10/15, 4/1/17, 1/1/18