Graham Hospital
210 W. Walnut
Canton, IL 61520
P: 309-647-5240
F: 309-649-5110

Graham Medical Group
Canton, Elmwood, Farmington, Galesburg, Glasford, Lewistown, Macomb & Williamsfield

Mailing Address:
Patient Financial Advocates
180 S. Main St.
Canton, IL 61520
P: 309-647-0201
F: 309-649-8948

Graham Home Medical Equip
101 S. Main St.
Canton, IL 61520
P: 309-647-7207
F: 309-647-7236

Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing the application below will help Graham Health System (GHS) determine if you are eligible to receive free or discounted healthcare services, or qualify for other public programs that may help pay for your care. Financial assistance is only available for medically necessary services. Financial assistance does not apply to the Graham Health System Intermediate Care Facility.

If you are uninsured, a Social Security Number is not required to receive free or discounted care. However, a Social Security Number is required for some public programs, including Illinois Medicaid. Providing a Social Security Number will help GHS in determining whether you qualify for any public programs.

To apply for free or discounted care, please complete the form below and return in person, by mail, or by fax to any of the locations listed above or online to FinancialAssistance@grahamhospital.org. This form must be returned within 60 days of receiving services.

For proof of income, or asset verification, we require (for all people in the household):

- **A copy of your most recent Federal Income Tax Return**
- **A copy of your last month's checking and/or savings account**
- **Copies of your last three pay stubs**
- **If unemployed, provide the state unemployment claim/stub**
- **If retired, disabled or on Social Security: copies of your monthly benefit**
- **Proof of alimony or child support**
- **Copies of your Health Savings Account (HSA) if applicable**
- **Documentation for asset verification (Money Markets, CDs, IRAs, etc.)**

If you are unable to supply the necessary documents above, please provide a written statement explaining your current situation. Please do not mail original documents. Send copies only.

Patient acknowledges that they have made a good faith effort to provide all information requested in the application to assist GHS in determining whether the patient is eligible for financial assistance. Patient further agrees GHS can check employment and credit history if necessary.

Need help completing this form? Patient Financial Advocates are happy to assist! They are located at the clinic, on the first floor near the lab, as well as at the Hospital, on the main level, near the cashier.

They can also be reached by calling 309-649-6818 or by emailing GHSBusinessServices@grahamhospital.org.

Revised: 04/2025

Spouse Personal Information

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ Birthday:_____

SSN#:_____ Employer:_____ Status: ☐PT ☐FT

Income

Income	You	Spouse
Gross Monthly Wages	$_____	$_____
Unemployment Monthly	$_____	$_____
Social Security/Disability Monthly	$_____	$_____
Retirement/Pension Monthly	$_____	$_____
Alimony or Child Support Monthly	$_____	$_____
Other	$_____	$_____

Additional Information

	Institution	Balance
Checking Account	_____	$_____
Savings Account	_____	$_____
Money Market/CDs/IRAs HSA/FSA	_____	$_____

	Loan Institution	Balance Owed
Motor Vehicle	_____	$_____
Home ☐Rent ☐Own	_____	$_____
Other (Boats, RVs, Etc.)	_____	$_____
	_____	$_____

Things to Consider with My Application

Revised: 04/2025

Graham Health System reserves the right to reverse any financial assistance decision in the event that you falsified data or failed to disclose financial information on your application for financial assistance. If there is a pending liability claim, workman's compensation claim or insurance claim, financial assistance cannot be applied and may be reversed at any time. You must inform a Patient Financial Advocate, in writing, of any changes in your financial circumstances affecting your ability to pay any balance due from you.

Consent/Certification Statement:

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 GHS bills. I understand that the information provided may be verified by the GHS and I authorize GHS 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 health system bills.

Complaints or concerns with the uninsured patient discount application process or GHS financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General.
Health Care Hotline: 1-877-305-5145 (1-800-964-3013) www.illinoisattorneygeneral.gov/consumers

_____

Preparer's Signature Date

_____

Preparer's Printed Name

For Internal Use Only	
Date Returned – Calendar Effective Year	
Total Gross Income	
Prior Year Taxes – Gross Income	
# of Eligible Dependents	
FPL & Charity Care % Approval	
Approver/Date	