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

**Graham Medical Group** 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.

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 the health system 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. This form must be returned within 60 days of receiving services.

**For proof of income, 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**

**If 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 he or she has made a good faith effort to provide all information requested in the application to assist the hospital 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 second floor across from the elevators, as well as at the Hospital, on the first floor, near the cashier.
They can also be reached by calling 309-649-6818, or visiting www.grahamhealthsystem.org.

GRAHAM HEALTH SYSTEM

## Applicant Personal Information

Last Name:_____ First Name:_____ MI:_____

Address: _____ City:_____

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

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

## Spouse Personal Information

Last Name:_____ First Name:_____ MI:_____

Address: _____ City:_____

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

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

## List Individuals Living in the Household (under the age of 18 or full-time students)

| Name | Relationship | DOB | SSN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Income

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

## Additional Information

| | Institution | Balance |
|---|---|---|
| Checking Account | _____ | $_____ |
| Savings Account | _____ | $_____ |
| Money Market/CDs | _____ | $_____ |
| | **Loan Institution** | **Balance Owed** |
| Motor Vehicle (Make/Model) | _____ | $_____ |
| Home ☐Rent ☐Own | _____ | $_____ |
| Other (Boats, RVs, etc) | _____ | $_____ |
| | _____ | $_____ |

## Things to Consider with My Application

**Graham Health System reserves the right to reverse any charity assistance in the event that you falsified data or failed to disclose financial information on your application for charity assistance. If there is a pending liability claim, workman's compensation claim or insurance claim, charity 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.**

**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 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.

_____

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 | |