Carle Community Care Discount Program

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Carle offers the Community Care Discount Program to provide discounted care to those who qualify. Completing this application will help The Carle Foundation Hospital, and other participating Carle entities (a.k.a. Carle) determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form and submit it to the hospital 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.

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 Carle determine whether you qualify for any public programs.

For additional information regarding our programs, please use the various contact information below.

Carle Patient Financial Services
Attn: Community Care
PO Box 6002
Urbana, IL 61803-6002
Phone: (217) 326-3099 or (888) 71-CARLE
Fax: (217) 326-8208
Email: CommCare@Carle.com
Website: Carle.org

By submitting this application, the patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Carle in determining whether the patient is eligible for financial assistance. Carle will review the application and determine which assistance programs at Carle would be most beneficial for the patient.

The application requires you to certify your household's current monthly income, household size, assets, and residency. It is your responsibility to cooperate throughout the application process by completing the application and providing the requested information. Carle will seek payment from health insurers and from government payors if such payment might be available. Qualification decisions are based on the household's "gross income", which means gross household earnings compared to the Federal Poverty Level (FPL). The FPL varies with the size of the family and is reviewed annually. While your application is pending, Carle will not try to collect the bills for which you are seeking assistance.

Carle will notify you whether your application has been approved or denied. If you disagree with the decision, you may appeal the decision to the Manager of Receivables Management within 45 days of the decision at the following address:

Carle Patient Financial Services
Attn: Manager - Receivables Management
PO Box 6002
Urbana, IL 61803-6002

Application for Financial Assistance

Patient Information

Last Name	First	M.I.	Birth Date	Patient's MRN:
				Social Security Number:
Home Address	City	State	Zip	Home Phone:
				Cell Phone:
Employer's Name	Employer's Address			Work Phone:
				Email Address:

Insurance Company Name	ID #	Subscriber's Name	Illinois resident at time of treatment? ☐ Yes ☐ No

Is someone else responsible for your debt (spouse, legal guardian, etc.)? ■ Yes ■ No

Responsible party's full name and home address:	Home Phone:
	Cell Phone:

Family/Household Information

Number of individuals within your home that you are responsible for: _____ Number of dependents claimed on your taxes: _____	Is anyone else employed within your household? □ Yes (complete information below) □ No

Household member's name *(If more than 3, please list on separate page)*	Household member's employer, address & phone

Presumptive Eligibility

Please indicate if any of these categories apply to you. If any apply, you only need to submit your award letter for possible qualification in our assistance programs. You may not need to provide any other income documents.

☐ Homeless	☐ Illinois Medicaid (Title XIX)	☐ SNAP or WIC	☐ Low Income Home Energy Assistance Program (LIHEAP)	☐ Illinois Free Lunch and Breakfast Program

If none of the above presumptive eligibility categories apply, please review and attach the appropriate documentation upon return of this application.

Please provide the following information for **each** applicable family member and sign the certification statement below:

1) Copy of the most recent Federal tax return (1040)
2) Copy of the most recent pay stubs for all employed family members or self employment income and expenses
3) Copy of the most recent checking and/or savings bank statements
4) If applicable, copy of Social Security or Social Security Disability award letter
5) If applicable, copy of Unemployment Statement, Disability award, or Workers' Compensation award
6) If applicable, copy of Medical Flexible Spending Account or Health Spending Account funds available
7) Other income/asset sources (i.e. child support, alimony, pension, stocks, mutual funds, Certificate of Deposit, retirement income and/or letter from employer - if paid in cash, etc.)

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 bill. I understand that the information provided may be verified by Carle, and I authorize Carle 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 bill(s).

Applicant Signature:_____ Date:_____