Please complete this application and submit to any Carle Health location in person, by mail, by email, or by fax to apply for assistance within 90 days following the date of discharge or receipt of services.

The application requires you to certify your household's gross annual income, household size and residency. It is your responsibility to cooperate throughout the application process. While your application is pending, Carle Health will not attempt to collect the bills for which you are seeking assistance.

For additional information, or to submit this application, please use the various contact information below:

Carle Health Financial Assistance Program
P.O. Box 4024, Champaign, IL 61824-4024
Phone: (888) 712-2753 **Fax:** (217) 902-7720
Email: FinancialAssistance@carle.com
Website: carle.org/FinancialAssistance

Carle Health Financial Assistance Program application, plain language summary, web materials and policies are available in Spanish.

La solicitud del Programa de asistencia Financiera de Carle Health, resumen en términos sencillos, contenido web y políticas están dispon ibles en español.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General toll-free hotline at (877) 305-5145 (TTY (800) 964-3013).

The Carle Foundation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-217-383-2543.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-217-326-0340.

CarleHealth
carle.org

HMKT030625A INS-1210-D-0

Financial Assistance Programs

Carle Health Financial Assistance Programs

Carle Health offers financial assistance programs to provide discounted care to those who qualify. Here are some general guidelines about the programs:

1. Eligibility is based on your household's adjusted gross income as reported on the prior year's Federal Tax Return and family size. If you are claimed as a dependent on another's Federal Tax Return, you will need to submit their Federal Tax Return as well.
2. We will approve and apply discounts only after all third-party payments have been received.
3. Before granting discounted care, we may ask you to apply for public assistance.** The Carle Health Case Management department will be happy to help you fill out application forms. For more information on applying for federal assistance, please visit hfs.illinois.gov/medicalclients/medicaidguide/applying.
4. Discounts will extend for one year from the date of approval. To continue to receive financial assistance, a new application must be submitted yearly.
5. These programs are open to new and existing patients who meet certain residency requirements.
6. Uninsured hospital patients who meet certain requirements may qualify for an uninsured discount, and your qualified hospital expenses may be limited to 20% of your gross annual income.
7. Carle Health staff will review your application and, if approved, match you with the assistance program that is best for you.
8. Carle Health reserves the right to require patients to produce additional information in order to verify income and/or assets.

Completing this financial assistance application will help Carle Health determine if you can receive free or discounted services (Carle Health Financial Assistance Program, Carle Health Regional Financial Assistance Program or Illinois Hospital Uninsured Patient Discount Program) or determine if you might qualify for other public programs that can help pay for your healthcare.

**Does not apply to patients applying for care at a designated Rural Health locations.

2025 Carle Health Financial Assistance Programs (CFAP) Effective Date 3/1/2025

Family Size	200%	300%	400%	600%
1	$31,300	$46,950	$62,600	$93,900
2	$42,300	$63,450	$84,600	$126,900
3	$53,300	$79,950	$106,600	$159,900
4	$64,300	$96,450	$128,600	$192,900
5	$75,300	$112,950	$150,600	$225,900
6	$86,300	$129,450	$172,600	$258,900
7	$97,300	$145,950	$194,600	$291,900
8	$108,300	$162,450	$216,600	$324,900
Add per Each Additional Person	$11,000	$16,500	$22,000	$33,000
Program Eligibility	100% CFAP	50% CFAP and IL Hospital Uninsured Discount Program Max	CAP 40% of income	IL Hospital Uninsured Discount Program Max

Application for Financial Assistance

CARLE HEALTH FINANCIAL ASSISTANCE PROGRAMS · ILLINOIS UNINSURED HOSPITAL PATIENT DISCOUNT PROGRAM

DEMOGRAPHICS	PATIENT/APPLICANT	SPOUSE (OR RESPONSIBLE PARTY)
Name		
Social Security Number[1]		
Date of Birth (MM/DD/YYY)		
Race*		
Ethnicity*		
Sex*		
Preferred Language*		
Address	Street: City: State: Zip:	Street: City: State: Zip:
Email Address		
Primary Phone Type/Number	☐ Mobile ☐ Home	☐ Mobile ☐ Home
Employer		
Marital Status	☐ Single ☐ Married	☐ Single ☐ Married

PATIENT'S INSURANCE INFORMATION

Insurance Company Name:	
Insurance Policy Number:	Insurance Effective Date:

FAMILY/HOUSEHOLD INFORMATION

What is the number of individuals within your household that you claim on your Federal Tax Return?

Are you claimed as a dependent on anyone else's Federal Tax Return? ☐ No ☐ Yes, Submit their Tax Return with your application.

HOUSEHOLD MEMBER INFORMATION

Name(s)	Date of Birth	Insurance

PRESUMPTIVE ELIGIBILITY SCREENING

Please indicate if any of these categories apply to you. Current participation within the program is required for certification purposes. You may need to supply required documents listed below.

☐ Homeless ☐ Illinois Medicaid ☐ SNAP or WIC ☐ Low Income Home Energy Assistance Program (LIHEAP) or Township Assistance

REQUIRED DOCUMENTS

If none of the presumptive eligibility categories apply, please review and attach the appropriate documentation for each wage earner in the family with this complete application.

Required

1. Copy of your most recent Federal tax return that you filed or were claimed as a dependent on.
2. Copy of most recent pay stubs for all employed family members for current and prior year, showing Year-to-Date Gross income.
3. Copy of self employment income and expenses for the current and prior year.
4. Copy of Social Security or Social Security Disability award letter for the current and prior year.
5. Copy of Unemployment statement, Disability award, or Workers Compensation award.
6. Copy of Medical Flexible Spending Account or Health Spending Account funds available.
7. Other income source documentation (i.e. child support, alimony, retirement income and/or letter from employer-if paid in cash)
8. Medicare Part A or Part B beneficiaries must also provide current bank statements from any checking, savings or investment accounts.
9. Written statement if cannot supply the above required documents

ASSET VERIFICATION**

Documentation and proof of assets:
-Checking and savings accounts statements.
-Investments: certificates of deposit (CDs), mutual funds, stocks and bonds statements.

Review & Sign

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 Health, and I authorize Carle 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, and any financial assistance granted to me will be reversed, and I will be responsible for payment of the bill(s).

Applicant Signature:	Date:

IMPORTANT INFORMATION

[1] 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 Health determine whether you qualify for any public programs. Carle Health 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 Self Pay Receivables Management within 45 days of the decision at the following address: Carle Health Patient Financial Services Attn: Manager - Self Pay Receivables Management, P.O. Box 4024, Champaign, IL 61824-4024

**Optional. Responses and nonresponses will not have any impact on the outcome of the application.*

*** Does not apply to patients applying for care at designated Rural Health locations.*

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