Financial Assistance Application

Carle Health knows there are times when our patients cannot pay for the services provided. If you need help paying for medical services, you may be eligible for financial assistance.

To see if you qualify for financial assistance, please carefully follow the instructions inside.

CarleHealth

HOW TO QUALIFY FOR FINANCIAL ASSISTANCE

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Carle Health determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

Be sure to give full information for everyone living in your home and complete all three sections on the right side of the form. If you don't return complete information, your request cannot be processed. All information will be kept private.

If you already receive help from a state program (like Food Stamps or WIC), fill out the first page of the application and send it in with proof that you are in one of these programs, such as a notice of decision. Also, be sure to sign the last page of the application. You may qualify for automatic participation in our program.

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 the hospital in determining whether the patient is eligible for financial assistance.

Providing Your Social Security Number Information

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 determine whether you qualify for any public programs.

When to Submit Your Financial Assistance Application

Please complete this form and submit to the hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care. NOTE: The requirement to complete and submit this form within 90 days following the date of discharge or receipt of outpatient care may be increased by the hospital, but not decreased.

How to Submit Your Application

Please submit this application one of the following ways:

- If by mail, to the following address:
  Central Billing Office
  Attn: FA Team
  P.O. Box 35758
  Des Moines, IA 50315-4205
- If by email, to: FA_CBO_Request@UnityPoint.org.
- If by fax, to: (515) 362-5055. Write "FA Application" on the fax cover sheet.

Assistance with Completing the Application

We can help with this form if you have questions.

- If you are in the hospital, ask for someone in Patient Registration to help you.
- If you are at home or in the clinic, call (844) 849-1260.

Additional Important Notes

Our team members may try to find out if you qualify for other federal or state assistance programs prior to processing your request for financial assistance from Carle Health.

Financial assistance is only available for medically necessary services provided by Carle Health organizations and physicians, as outlined in our Financial Assistance Policy. If you would like to learn more about this policy, visit carle.org/FinancialAssistance. If you have more questions about your bill, please call the phone number listed on the bill to talk to the hospital, clinic or home care that provided the care.

COMPLETE ALL THREE SECTIONS

1. Send complete information and remember to sign the form: Fill the attached form out completely. Please remember to sign the bottom of the last page. You only need to fill out one form for everyone living in your home.

2. Proof of Income for everyone in your home:
   Send copies of all items listed below that apply.

- ☐ Tax return for last year.
- ☐ If you are employed: a pay stub with year-to-date income OR your last three pay stubs.
- ☐ If you are self-employed: balance sheet and income statement.
- ☐ If you are unemployed: state unemployment claim AND final pay stub from last job.
- ☐ If you are paid in cash: written income verification is required from employer.
- ☐ Monthly pension amount letter.
- ☐ Disability income amount letter.
- ☐ Social Security income amount letter.
- ☐ Proof of income from rent.
- ☐ Proof of income from child support.
- ☐ Proof of income from alimony.
- ☐ If you have NO income, written statement from the person who supports you.

3. Provide Proof of Assets for everyone in your home:
   Send copies of all items listed below that apply.

- ☐ Bank statements from the last three months.

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You may experience a delay in the processing of your application if all information is not provided.

- ☐ Proof of ALL income in household for those over 21 years of age.
- ☐ Three months of bank statements, checking/savings, include ALL pages.
- ☐ Last year's 1040 tax return with ALL schedules.

PATIENT INFORMATION

Name _____
(Last) (First) (MI

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Email _____

Birthday _____ Age _____

SSN _____ Marital Status ☐ Y ☐ N

Race (Optional)

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity (Optional) _____

Sex (Optional) ☐ M ☐ F ☐ Other _____

Preferred Language (optional): _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____
(Last) (First) (MI)

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Email _____

Birthday _____ Age _____

SSN _____ Marital Status ☐ Y ☐ N

Personal Employment:

Employer _____

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Job Title _____

Job Status ☐ PT ☐ FT Avg. Weekly Hours _____

SPOUSE OF PERSON RESPONSIBLE FOR PAYMENT

Name _____
(Last) (First) (MI)

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Email _____

Birthday _____ Age _____

SSN _____ Marital Status ☐ Y ☐ N

Personal Employment:

Employer _____

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Job Title _____

Job Status ☐ PT ☐ FT Avg. Weekly Hours _____

OTHER INFORMATION

List All Other People Living in the Household:

Name	Relationship	SSN	Birthdate

Second Employer for Responsible Party and/or Spouse:

Employer _____

Address _____
(Street)

_____
(City) (State) (ZIP)

Telephone _____

Job Title _____

Job Status ☐ PT ☐ FT Avg. Weekly Hours

All columns must be completed.

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INCOME

Source of Income *(Must Provide Documentation)*	Amount Received	How Often Received	Name of Person Receiving
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Comp/Unemployment			
Interest/Dividend			
Other (Explain)			

ASSETS

Item	Acct. Balance	Description	*Provide three months of statements.
Checking Account*			
Savings Account*			

EXPENSES

Item	Total Amount Owed	Monthly Payments	Description
Home Mortgage			
Rent (Monthly Payment)			
Utilities (Electricity, Water, etc.)			
Groceries and Child care			
Medical Bills			
Alimony/Child Support			
Prescription Medicines			
Bank Loans (Personal, Student Loans, etc.)			
Insurance (Auto, Health, etc.)			
Credit Card Debt			
Other (Explain)			
Total Expenses (Add all lines above.)			

Consents for Release of Information/Certification Statements

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.

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.

(800) 243-0618 IllinoisAttorneyGeneral.gov/

Preparer's Signature Date

Spouse's Signature Date

Your complete application and all supporting documents* may be submitted via:

Mail:
Central Billing Office
Attn: FA Team
P.O. Box 35758
Des Moines, IA 50315-4205

*Do not mail original documents. Send copies only. Documents will be destroyed after being scanned.

Email: FA_CBO_Request@UnityPoint.org
Fax: (515) 362-5055
Write: **"FA Application"** on fax cover sheet.

Questions? Please email FA_CBO_Request@UnityPoint.org or call (844) 849-1260.