Boyd Healthcare Services
800 School St.
Carrollton, IL 62016

Patient Financial Assistance Program

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Boyd Healthcare Services determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to Boyd Healthcare Services.

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.

Before considering this form, we are required to make sure that all available insurances, Medicare, Medicaid and other liable parties have been billed. If we feel you may qualify for Medicaid, we can require that you apply for Medicaid at the Department of Human Services before considering your application.

Please complete this form and submit it to the hospital in person, by mail, or by fax to apply for free or discounted care. If you are applying for the uninsured discount, the application must be submitted within 60 days following the date of discharge or receipt of outpatient care. Otherwise, the discount will be calculated under the Boyd Cares program 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.

Financial assistance and Illinois Uninsured Patient Discounts may be granted for full or partial payment of hospital bills based on income relative to the federal poverty guidelines and consideration of other aspects of each patient's financial and medical situation.

Our contact information:

Boyd Healthcare Services
Attn: Patient Financial Assistance Program
800 School St.
Carrollton, IL 62016
Phone: (217) 942-6946
Fax: (217) 942-9012

Thank you for choosing Boyd Healthcare Services for your healthcare needs.

BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME ADDRESS		TELEPHONE NUMBER
CITY, STATE, ZIP		MARITAL STATUS
NAME AND ADDRESS OF EMPLOYER		EMPLOYER TELEPHONE NUMBER

FAMILY INFORMATION

SPOUSE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME ADDRESS, IF DIFFERENT THAN ABOVE		TELEPHONE NUMBER
NAME AND ADDRESS OF SPOUSE'S EMPLOYER		EMPLOYER TELEPHONE NUMBER
TOTAL NUMBER IN FAMILY/HOUSEHOLD ____________ ***Only dependent children claimed on tax return can be included in household. A non-minor child living at home must apply separately unless claimed on parents' tax return.	NAMES AND AGES OF DEPENDENTS (CHILDREN)	

PROOF OF IL RESIDENCY

PLEASE PROOF OF ILLINOIS RESIDENCE (a valid state-issued ID, recent residential utility bill, lease agreement, vehicle registration card, voter registration card, mailed addressed to the uninsured patient at an IL address from a government or other credible source, a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility).

PROOF PROVIDED?	☐ YES ☐ NO

PRESUMPTIVE ELIGIBILITY - Uninsured Discount Analysis

Are you uninsured?	☐ YES ☐ NO	**If yes, answer remaining questions in this section.** **If no, do not answer remaining questions in the section and move to "monthly family income" section.**

DECEASED WITH NO ESTATE	☐ YES ☐ NO		HOMELESS	☐ YES ☐ NO		MEDICAID ELIGIBLE, BUT NOT ON THE DATE OF SERVICE	☐ YES ☐ NO	
MENTAL INCAPACITATION	☐ YES ☐ NO	*****IF YOU HAVE ANSWERED YES TO ANY QUESTION IN THIS SECTION, DO NOT PROCEED WITH REMAINDER OF THE FORM, EXCEPT FOR "PATIENT AGREEMENT" ON PAGE 2. IF YOU HAVE ANSWERED NO, PROCEED TO NEXT SECTION.**						

MONTHLY FAMILY INCOME

VERIFICATION: **<u>Proof of income eligibility MUST BE PROVIDED</u> from the following acceptable forms of documentation for each source of household income:** Examples include a copy of the most recent tax return, copies of the two most recent pay stubs, or W-2 and 1099 forms (Preferred), written income verification from an employer if paid in cash, other reasonable form of third party income verification as deemed acceptable by the hospital, benefit statements, court orders, etc.

☐ WEEKLY ☐ MONTHLY ☐ ANNUAL

DESCRIPTION	BALANCE	DESCRIPTION	BALANCE	DESCRIPTION	BALANCE
PATIENT GROSS INCOME		RENTAL INCOME		WORKERS COMP	
SPOUSE GROSS INCOME		ALIMONY/ CHILD SUPPORT		PENSION	
SOCIAL SECURITY		UNEMPLOYMENT		OTHER	
INTEREST/ DIVIDENDS		DISABILITY		OTHER	

TOTAL MONTHLY INCOME AMOUNT: ____________

PROOF PROVIDED?	☐ YES ☐ NO

BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION (Continued)

IF APPLICABLE. MEDICALLY INDIGENT STATUS DETERMINATION:

The following information is NOT factored in to the determination of financial need eligibility, thus not required to be submitted by the patient UNLESS the patient would like to be evaluated for medically indegent status. To be considered medically indigent, the patient portion of all medical expenses compared to household income and disposable assets would then cause the applicant to be less than 200% of the Federal Poverty Level.

Total Medical Expenses (including all outside expense): ____________________

*** You must provide current copies of all medical bills to show balance owed.**

COPIES OF ALL MEDICAL BILLS PROVIDED?	☐ YES ☐ NO

Other Assets: Please provide copies of the two most recent statements of the following asset information:

DESCRIPTION	BALANCE	DESCRIPTION	BALANCE	DESCRIPTION	BALANCE
CHECKING ACCOUNT		HEALTH SAVINGS/ FLEX SPENDING		CERTIFICATE OF DEPOSIT	
SAVINGS ACCOUNT		STOCKS / MUTUAL FUNDS		OTHER	

LIST OTHER ASSETS OWNED OTHER THAN PRIMARY RESIDENCE (VEHICLE, BOAT, CAMPER ETC) AND ESTIMATED VALUE:

DESCRIPTION: ____ ESTIMATED VALUE:________

OTHER INFORMATION

ADDITIONAL COMMENTS: ____

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PATIENT AGREEMENT

The undersigned applies for financial assistance in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The creator will retain the original or a copy of this application, even if financial assistance is not granted. The undersigned also agrees to allow Boyd to contact any or all of the above references for credit verification, including credit bureaus. The falsification of data may result in the reversal of any financial assistance.

Patient Signature:____ Date____________________

Responsible Party or Spouse Signature:____