THOMAS H BOYD MEMORIAL HOSPITAL
d/b/a BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL)
NAME OF GUARANTOR IF DIFFERENT THAN PATIENT (PERSON RESPONSIBLE FOR PAYING THE BILL)		GUARANTOR RELATIONSHIP TO PATIENT
HOME ADDRESS		TELEPHONE NUMBER
CITY, STATE, ZIP		MARITAL STATUS
NAME/ADDRESS OF EMPLOYER (STATE IF SELF-EMPLOYED, DISABLED, RETIRED OR UNEMPLOYED, IF APPLICABLE)		EMPLOYER TELEPHONE NUMBER

PLEASE PROVIDE ANY MEDICAL INSURANCE INFORMATION, IF APPLICABLE:

INSURANCE COMPANY NAME:

ID NUMBER AND GROUP NUMBER:

SUBSCRIBER NAME:

OPTIONAL PATIENT INFORMATION

Patient responses or nonresponses in the below section are **OPTIONAL** will not have any impact on the outcome of the application.

RACE	☐ WHITE ☐ ASIAN ☐ NATIVE HAWAIIN / PACIFIC ISLAND ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN INDIAN / AMERICAN NATIVE		
ETHNICITY	☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO	PREFERRED LANGUAGE	☐ ENGLISH ☐ OTHER, PLEASE DESCRIBE:
GENDER AT BIRTH	☐ MALE ☐ FEMALE	PREFERRED GENDER, IF DIFFERENT	

FAMILY/HOUSEHOLD INFORMATION

SPOUSE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL)
HOME ADDRESS, IF DIFFERENT THAN ABOVE		TELEPHONE NUMBER
NAME/ADDRESS OF SPOUSE EMPLOYER (STATE IF SELF-EMPLOYED, DISABLED, RETIRED OR UNEMPLOYED, IF APPLICABLE)		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)	

PRESUMPTIVE ELIGIBILITY

Please check if any of the following apply and provide proof of program eligibility (ex. Approval letter from state department for program)

- ☐ DECEASED WITH NO ESTATE
- ☐ HOMELESS
- ☐ INCARCERATION IN PENAL INSTITUTION
- ☐ MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF
- ☐ MEDICAID ELIGIBLE, BUT NOT ON THE DATE OF SERVICE OR NON-COVERED SERVICE
- ☐ ENROLLED IN WIC, SNAP, LIHEAP, TANF, or IL FREE LUNCH AND BREAKFAST PROGRAM

*****IF YOU HAVE MARKED THAT ANY OF THE ABOVE APPLY IN THIS SECTION AND PROVIDED SUPPORTING DOCUMENTATION, YOU DO NOT NEED TO COMPLETE FAMILY INCOME SECTION.**
IF NONE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES APPLY, PROCEED TO FAMILIY INCOME SECTION.

FAMILY INCOME

VERIFICATION: **Proof of income eligibility MUST BE PROVIDED 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.

Please check proof of income included with application for entire household (patient, sspouse, dependents). This is REQUIRED.

- ☐ MOST RECENT FEDERAL TAX RETURN (i.e. 1040)
- ☐ MOST RECENT W-2'S, OR 1099 FORMS
- ☐ COPIES OF 2 MOST RECENT PAY STUBS
- ☐ WRITTEN VERIFICATION FROM EMPLOYER IF PAID IN CASH
- ☐ OTHER BENEFIT STATEMENTS (i.e. SOCIAL SECURITY, ALIMONY/CHILD SUPPORT, UNEMPLOYMENT, PENSION, RENTAL INCOME, INTEREST/DIVIDEND INCOME)

TOTAL MONTHLY INCOME AMOUNT: _________________

THOMAS H BOYD MEMORIAL HOSPITAL
d/b/a BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION (Continued)

OPTIONAL INFORMATION: IF APPLICABLE, ASSET INFORMATION

The following information is NOT factored eligibility for financial assistance using the sliding scale, 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.

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.

If I have questions or concerns, I understand that I may contact the Hospital's Patient Financial Councelor at 217-942-6946. 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 at:
https://illinoisattorneygeneral.gov/consumers/healthcare.html
Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)

Signature of Patient or Applicant:____ Date___________________