

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Crawford Memorial Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

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.

Please complete this form and submit it to the appropriate office listed in the contact information below 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.

Contact information:	Crawford Memorial Hospital	or	CMH Clinic Billing
	Attn: Business Office		1002 N. Allen St, Suite B
	1000 N. Allen St.		Robinson, IL 62454
	Robinson, IL 62454		Phone (618) 544-5517
	Phone (618) 546-2568, Fax (618) 544-3821		Fax (618) 546-2675

*To be considered for our **Hospital Financial Assistance Program**, you must have a denial letter from State Medicaid if your income is less than 134% of the federal poverty level. To be considered for the Financial Assistance for the **CMH Rural Health Clinics** all that is required to be submitted is family size and proof of income. In order to share the same financial assistance application between the hospital and clinic, the asset and expense portion must be completed for the Hospital Financial Assistance Program but will not be considered for the CMH Rural Health Clinics. Patient acknowledges that he or she has made a good faith effort to provide all information required in the application for the Hospital or CMH Rural Health Clinic to determine whether the patient is eligible for financial assistance

Financial Assistance (and Illinois Uninsured Patient Discount) Form Instructions

Before considering this form, we are required to make sure that all available insurances, Medicare, Medicaid, and other liable parties have been billed.

1. This form may be filled out by any person with knowledge of the patient and/or guarantor's financial situation. We will send our response to the responsible party on the patient's accounts.
2. Complete the entire disclosure form, including your signature. We may request proof of address and/or dependents.
3. Source of Income should list all family income - employment, retirement, pension, Social Security, etc. Please supply:
 - 3 most recent check stubs showing year-to-date totals, or your most recent tax return.
 - If drawing unemployment or social security, we will need proof of the amount.
 - If you are not presently employed, we need the most recent bank statement, a signed note from the person paying your living expenses or from the person you live with. The note should include that you are unemployed and unable to draw unemployment compensation.
4. If you owe more than \$1000 to other hospitals or physicians and will supply copies of most recent bills or statements, that will be taken into consideration of the financial assistance outcome.
5. The Asset portion of the form will not be utilized in the determination for National Health Service Corp sliding fee scale eligibility.
6. Please return the completed form, with the documentation, within 30 days to the address/fax above. We will normally respond within 14 days either with a request for more information or with a decision.

Financial assistance and Illinois Uninsured Patient Discounts may be granted for full or partial payment of CMH bills based on income relative to the federal poverty guidelines and consideration of other aspects of each patient's financial and medical situation. Any amounts remaining after financial assistance or discount have been granted are your responsibility and we will work with you to set a reasonable payment arrangement. For questions, please contact the appropriate business office listed in the contact information.

Nondiscrimination statement:

Crawford Hospital District 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 1-618-546-2657.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-546-2657.

Notice of Availability of Language Assistance Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-546-2657 (TTY: 7-1-1).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-546-2657 (TTY: 7-1-1).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-546-2657 (TTY: 7-1-1).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-546-2657 (TTY: 7-1-1)。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-618-546-2657 (TTY: 7-1-1).

تنبيه: 1-618-546-2657 بالرقم اتصل. مجانًا اللغوية المساعدة خدمات لك تتوفر، العربية اللغة تتحدث كنت إذا: تنبيه

ATENÇÃO: Se você fala português, os serviços de assistência linguística estão disponíveis gratuitamente. Ligue para 1-618-546-2657 (TTY: 7-1-1).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 1-618-546-2657 (телетайп: 7-1-1).

સાવધાની: જો તમે ગુજરાતી બોલતા હોવ, તો ભાષા સહાયતા સેવાઓ તમને મફતમાં ઉપલબ્ધ છે. 1-618-546-2657 (TTY: 7-1-1) પર કોલ કરો.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-618-546-2657 (TTY: 7-1-1).

ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Звоните по номеру 1-618-546-2657 (TTY: 7-1-1)

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-618-546-2657 (TTY: 7-1-1) 로

전화하십시오.

ATTENTION: Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le 1-618-546-2657 (TTY: 7-1-1).

PAŽNJA: Ako govorite srpsko-hrvatski, besplatne usluge jezičke pomoći su vam dostupne. Pozovite 1-618-546-2657 (TTY: 7-1-1).

IKILO: Ti o ba so Yoruba, awon ise iranlowo ede, laisi idiyele, wa fun o. Pe 1-618-546-2657 (TTY: 7-1-1).

ATTENZIONE: Se parli italiano, i servizi di assistenza linguistica sono disponibili gratuitamente. Chiama il 1-618-546-2657 (TTY: 7-1-1).