



Hamilton Memorial Hospital
611 S. Marshall Ave.
McLeansboro, IL 62859

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Hamilton Memorial Hospital to process your application, all sections must be completed. Please complete this form and submit it to the hospital with the following documents to apply for free or discounted care within 90 days of receiving the application:

- Most recently filed federal tax return document (1040 Form)
Most recent Social Security Benefit Letter
Received Application on date:

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information.

Applicant Name: Last Name First Name Middle Name Date of Birth:
Address: City: State: Zip Code:
Phone Number: Email:

The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.

Race: American Indian or Alaskan Native Black or African American Native Hawaiian or Other Pacific Islander White
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Sex: Male Female Undetermined
Preferred Language: English Spanish Polish Chinese Arabic Russian Other

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card.

Yes No Insurance Company: Member ID: Group Number:
If no, have you applied for Medicaid? Yes No
If yes, what is the status of your Medicaid application? Approved Denied Pending

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS' INFORMATION

Please provide the below information for all immediate family members who are included in your most recent Tax Return.

Table with 3 columns: Family Member Name(s), Date of Birth, Relationship to Applicant



APPLICATION FOR FINANCIAL ASSISTANCE

*Our Financial Assistance Program applies to services provided by Hamilton Memorial Hospital District. Our Financial Assistance Program does **not** apply to services performed by independent contractors, who are not employed by the hospital and bill separately for their services. For a list of independent contractors at HMHD, please visit hmhospital.org.*

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 medical bill(s). I understand that the information provided may be verified, and I authorize Hamilton Memorial 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 medical bill(s). I grant Hamilton Memorial Hospital permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____

Questions or Concerns

If you have questions or concerns, you may contact Hamilton Memorial Hospital's Business Office by calling 618-643-2361 ext. 5200 or email at billing@hmhospital.org.

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:

Website: <https://www.illinoisattorneygeneral.gov/consumers/healthcare.html>

Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)