FAIRFIELD MEMORIAL HOSPITAL
DEACONESS ILLINOIS PARTNER

FAIRFIELD MEMORIAL HOSPITAL
303 NW 11TH STREET
FAIRFIELD, ILLINOIS 62837
618-842-2611

HORIZON HEALTHCARE
213 NW 10TH STREET, STE. A
FAIRFIELD, ILLINOIS 62837
618-842-4617

# APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME: _____PHONE #: _____

PATIENT ADDRESS: _____

EMPLOYER: _____

Important: You may be able to receive free or discounted care. Completing this application will help Fairfield Memorial Hospital 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 the hospital.

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.

Uninsured patients who demonstrate one of the following Presumptive Eligibility Criteria (homeless, mental incapacitation with no one to act on patient's behalf, Medicaid eligible but not on date of service) are automatically eligible to receive free care and no proof of income will be requested. We verify eligibility electronically, when possible, but may need you to assist us in demonstrating your eligibility.

Please complete this form and submit it to the hospital in person, by mail, or by fax to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care.

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. Their website is: https://www.illinoisattorneygeneral.gov/

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.

**HOUSEHOLD INCOME:**

$ _____Total **income** for the past twelve months for all members of the Household must be listed.
Proof of income **must be returned with this application** by providing copies of any of the following items including: Bank statements, IRS Form W-2, Wage and Tax Statements, Paycheck remittance, individual tax return, telephone verification by employer, Social Security payment remittances, Unemployment Insurance payment notices, Unemployment Compensation Determination letter, or other appropriate indicators of yearly, monthly, weekly or hourly income

| | | | |
|---|---|---|---|
| Wages | $_____ | Child Support | $_____ |
| Farm or Self-Employment | $_____ | Pension/ADC/Welfare | $_____ |
| Public Assistance | $_____ | Rental Income | $_____ |
| Social Security | $_____ | Insurance Disability | $_____ |
| Unemployment Compensation | $_____ | Other | $_____ |
| Worker's Compensation | $_____ | Other | $_____ |
| Alimony | $_____ | Other | $_____ |
| If unemployed, date last worked: _____ | | Check Here _____ if No taxes were filed this past year | |

APPLICANT'S NAME: _____

**HOUSEHOLD SIZE: _____**

| **NAME** | **DATE OF BIRTH** | **RELATIONSHIP** | **SSN** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*DEMOGRAPHIC INFORMATION FOR THE APPLICANT* ***

Race: _____

Ethnicity: _____

Birth Sex: _____

Preferred Language _____

***Responses or nonresponses by the applicant will not have any impact on the outcome of the application.*

I certify that the information in this application is true and correct to the best of my knowledge. 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.

Applicant's Signature: _____Date of Request _____

Spouse's Signature (if married): _____Date of Request _____

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☐ Application Approved ☐ Application Denied

_____

(Hospital Representative Signature) Date

Rev. 01.2026