Deaconess Illinois

FINANCIAL ASSISTANCE APPLICATION

Please complete this application as fully as possible and return within ten working days. Your application is not complete without proof of income and assets. Please do not send original documents, as we are unable to return these to you. If you report $0 income, please provide a brief explanation of how you are meeting your monthly expenses. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

YOU MUST PROVIDE PROOF OF GROSS HOUSEHOLD INCOME AND ASSET INFORMATION. THIS MAY BE IN THE FORM OF:

INCOME

1. LAST FOUR (4) PAY STUBS
2. LAST YEAR'S FEDERAL (1040) TAX RETURN & ANY SCHEDULES
3. SOCIAL SECURITY INCOME AWARD LETTER OR 1099
4. CHILD SUPPORT PAYMENT STATEMENT

ASSETS

1. RECENT BANK STATEMENTS SUPPORTING VALUE LISTED FOR CHECKING/SAVINGS ACCOUNTS, C.D.'S, SECURITIES, AND/OR FINANCIAL SETTLEMENTS

Please print all information using BLACK ink only

PATIENT INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City		State	Zip Code
Occupation	Employer	Length of Employment	Full Time / Part time	Hours per Week

RESPONSIBLE PARTY'S INFORMATION

Email:

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City		State	Zip Code
Occupation	Employer	Length of Employment	Full Time / Part time	Hours per Week

RESPONSIBLE PARTY'S SPOUSE INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Sex M F	Telephone No.	
Occupation	Employer	Length of Employment	Full Time / Part time	Hours per Week

DEPENDENTS (List self, spouse, and legal dependents)

Name	Age	Relation	Name	Age	Relation
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ASSETS (Must provide proof of value) **dollar amount:**

Cash on Hand	
Savings Account	
Checking Account	
C.D.'s	
Securities	
Home Value	
Other Real Estate	
Other	
TOTAL	

Vehicle Information

Make & Model	Year	Value
1.		
2.		
3.		

GROSS MONTHLY INCOME (Need proof of Income)

Applicant	
Applicant Spouse	
Social Security Income	
V.A. Pension	
Pension	
Unemployment	
Worker's Compensation	
Interest Income	
Dividend Income	
Child Support	
Alimony	
Income from Rental Property	
Other	
Other	
TOTAL	

I qualify for Food Stamps. ___ Yes ___ No

FINANCIAL SETTLEMENTS (Must provide proof of value):

Insurance	
Inheritance	
Other	
TOTAL	

I, (your name) _____
do solemnly state that the information contained on this application is true and accurate to the best of my knowledge and belief.

_____
Signature of Patient, Parent, Spouse or Legal Representative

_____
Date

DEBTS **dollar amount:**

Home Loan Balance	
Car Loan Balance	
Credit Card Balances:	
1. _____	
2. _____	
3. _____	
Other Debts:	
_____	
_____	
_____	
_____	
_____	
TOTAL	

MONTHLY PAYMENTS

Mortgage (PITI)	
Rent	
Utilities (Electricity, Water, Gas, etc.)	
Gas for Vehicle(s)	
Telephone / Cell Phone	
Cable/Internet	
Groceries/Household Necessities	
Furniture	
Car Payment	
Clothing	
Day Care	
Child Support	
Alimony	
Credit Cards	
Commerce Bank Repayment Plan	
Payments on Medical Bills:	
1. _____	
2. _____	
Insurance:	
Auto	
Property	
Medical	
Loan Payments:	
1. _____	
2. _____	
TOTAL	

Concerns or complaints with the financial assistance process may be reported to the Health Care Bureau of the Attorney General (below).
https://www.illinoisattorneygeneral.gov/File-A-Complaint/

KWAME RAOUL
ILLINOIS ATTORNEY GENERAL
Health Care Bureau
100 West Randolph Street
Chicago, IL 60601
Hotline Number: 1-877-305-5145 *** Fax Number: 1-312-793-0802 *** TTY: 1-312-964-3013
Website: www.IllinoisAttorneyGeneral.gov Email: HealthCare@ilag.gov

Deaconess Illinois

Mail or Fax to:

For dates of service prior to 8/18/24 mail to:
Heartland Regional Medical Center: 3333 W. DeYoung St. Marion, IL 62959 (Phone: 844-652-0603, Fax: 618-998-7613)

For dates of service after 8/18/24 mail to:
Deaconess Financial Assistance: P.O. Box 3366, Evansville, IN 47732
Email to: Financial.Assistance@deaconess.com
Phone: 812-450-3435 Fax: 812-450-5261

For dates of service prior to 9/15/24 mail to:
Crossroads Community Hospital: 8 Doctors Park Rd, Mt. Vernon, IL 62864 (Phone: 844-652-0605, Fax: 618-241-8697

For dates of service after 9/15/24 mail to:
Deaconess Financial Assistance: P.O. Box 3366, Evansville, IN 47732
Email to: Financial.Assistance@deaconess.com
Phone: 812-450-3435 Fax: 812-450-5261

For dates of service prior to 9/15/24 mail to:
Union County Hospital: 517 N. Main St. Anna, IL 62906 (Phone: 844-652-0604, Fax: 618-614-6186)

For dates of service after 9/15/24 mail to:
Deaconess Financial Assistance: P.O. Box 3366, Evansville, IN 47732
Email to: Financial.Assistance@deaconess.com
Phone: 812-450-3435 Fax: 812-450-5261

Red Bud Regional Hospital: 325 Spring St, Red Bud, IL 62278 (Phone: 844-652-0606, Fax: 618-282-7740

Processing your application may take 10-14 days. If additional information is needed a letter will be mailed and additional processing time will be needed.