Rochelle
Community Hospital

Date:

Dear:

Account Number(s): _____

Balance due at Rochelle Community Hospital: _____

Rochelle Community Hospital endeavors to provide quality health care to meet the needs of all people in the community it serves. Upon request, the hospital will process applications for uncompensated care from individuals who feel they are unable to pay for services rendered. You may be able to receive free or discounted care. Completing this application will help Rochelle Community Hospital to determine if you are eligible or if there are other public programs that can help pay for your healthcare.

If you are un-insured, 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. Medicaid eligibility may be an option for you. You may call our office or the county HFS/Medicaid office in the county you reside in for more details.

If you wish to apply for financial aid, please complete this form and submit it to the hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 120 days following the date of your first billing from the hospital. The patient must acknowledge that he/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 and sign the application. Provide copies of any and all of the following items as applicable for all people in the household. If unable to supply the necessary documents, provide a written statement explaining your current situation.

_____Financial Assistance Application Form

_____W-2 and/or 1099 statements, unemployment checks and/or retirement income

_____Pay check stubs or unemployment check stubs showing gross wages to date or last 3 months.

_____Statements from Social Security, Veterans Pension or Disability

_____Prior year income tax return if available

Have you recently declared person bankruptcy? Yes/No Date:_____

Were you incarcerated in a penal institute now or at time of your services? Yes/No

If bank statements are available to verify deposits automatically deposited into your account, please provide a copy.

Failure to provide this information within 120 days following the date of first billing you will be disqualified from assistance. Your cooperation with Rochelle Community Hospital is extremely important in determining your eligibility for assistance.

Upon receipt of the above documentation, you will receive a written notice from the hospital within 30 days indicating your eligibility and any payment obligation due from you.

Sincerely,

Doris Dickey, CPAM
Patient Financial Services Manager
Rochelle Community Hospital

Please return signed application and all documents to:

Patient Financial Services Department
Rochelle Community Hospital
900 North Second Street
Rochelle, IL 61068
Telephone:815-562-2181
Fax: 815-561-3121

05/2016