



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 can receive free or discounted services or other public programs that can help pay for your healthcare.

To qualify, the services must be medically necessary. Elective procedures do not qualify.

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 for more details.

If you wish 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 60 days following the date of discharge or receipts of outpatient care. 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. Please 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

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 60 days following the date of discharge or receipt of out-patient care, could disqualify you 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,

Zachary Heward
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
815-562-2181*