RIVERSIDE
HEALTHCARE

350 North Wall Street
Kankakee IL 60901
www.Riversidehealthcare.org
Telephone 1.815.935.7539
Fax 1.815.935.7490

Application to Determine Eligibility for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Riverside Medical Center 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.

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 receipt of outpatient care.

Please provide the documentation outlined below. Failure to do so may result in a delay or denial of your application. If you cannot provide the documentation, please provide a letter of explanation. Medicaid eligible recipients are not required to complete the application.

If you have questions or concerns, please reach out to Riverside's Patient Financial Department at 815.935.7539.

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. More information can be found at IllinoisAttorneyGeneral.com or by calling 877.305.5145

GROSS MONTHLY FAMILY INCOME – DOCUMENTATION

If the patient is ***uninsured***, please provide only one of the following items to verify the patient's income:

- ☐ A copy of the most recent Federal tax return of the patient or if the patient is a minor that of the parent or guardian
- ☐ Copies of the two most recent pay stubs

If the patient is ***insured***, please provide the following information:

- ☐ A copy of the most recent Federal tax return of the patient or if the patient is a minor that of the parent or guardian
- ☐ Current account statements (checking and savings)
- ☐ Copies of the two most recent pay stubs

PATIENT (APPLICANT) INFORMATION (Please print all information)			
Last Name:	First Name:		M.I.
Address:		Phone:	
City:	State:	Zip Code:	
Email Address:		Date of Birth:	
Social Security Number (not required if you are uninsured):			
Is the Applicant currently employed? If yes, please provide all employment information. Additional information may be provided on the reverse side of this form.			
Employer Name:			
Employer Address:		Employer Phone:	
Employer City:	Employer State:	Employer Zip Code:	

1. Was the patient a resident of Illinois when the services were rendered?	YES	NO
2. Was this service the result of an alleged accident?	YES	NO
3. Was this service the result of an alleged crime?	YES	NO

CO-APPLICANT INFORMATION (Spouse; Partner; Parent or Guardian of the Patient)			
Last Name:	First Name:		M.I.
Address:		Phone:	
City:	State:	Zip Code:	
Is the Co-Applicant currently employed? If yes, please provide all employment information. Additional information may be provided on the reverse side of this form.			
Employer Name:			
Employer Address:		Employer Phone:	
Employer City:	Employer State:	Employer Zip Code:	

FAMILY/HOUSEHOLD INFORMATION	
Number of persons in the patient's/applicant's family household:	
Number of persons who are dependents of the patient/applicant:	
Ages of patient's/applicant's dependents:	

GROSS MONTHLY FAMILY INCOME; please list all income for the household. Additional information may be provided on the reverse side of this form. Please check all that apply and give gross amounts, before taxes.	
☐ Wages	$
☐ Self-employment	$
☐ Unemployment compensation	$
☐ Social Security	$
☐ Social Security Disability	$
☐ Veterans' pension	$
☐ Veterans' disability	$
☐ Private disability	$
☐ Workers' compensation	$
☐ Temporary Assistance for Needy Families	$
☐ Retirement income	$
☐ Child support, alimony, spousal support	$
☐ Other income	$
GROSS MONTHLY FAMILY INCOME	$
Less payments made for child support	$
TOTAL GROSS MONTHLY FAMILY INCOME	$

CERTIFICATION:

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 hospital bill. 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.

Patient or Applicant Signature	**Date**

If returning by mail, please mail your application and documentation to Riverside Medical Center, Attention: Cashier, 350 N Wall St, Kankakee IL 60901.

If returning by fax, please fax your application and documentation to 1.815.935.7490.

If returning electronically, please email your application and documentation to CustomerService@RiversideHealthCare.net.

You may also return your application to any Riverside Medical Center location.

Thank you for choosing Riverside Medical Center for your healthcare needs.