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.

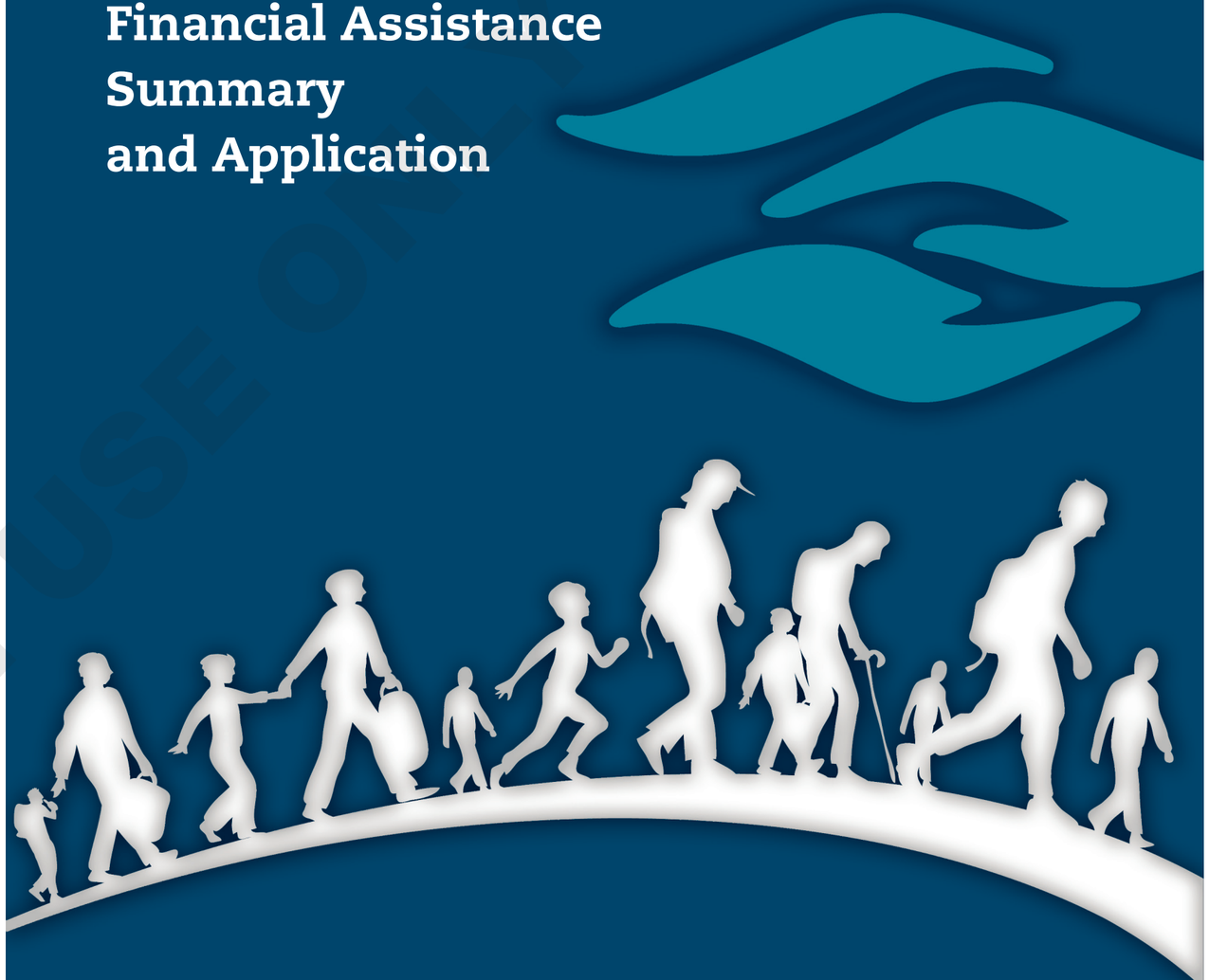
Patient or Applicant Signature	Date

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 (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 Healthcare location.

Thank you for choosing a Riverside Healthcare for your healthcare needs.

750942 (2/24)

RIVERSIDE HEALTHCARE
Financial Assistance Summary and Application



riversidehealthcare.org

RIVERSIDE HEALTHCARE

Riverside Healthcare's mission is to provide a remarkable healthcare experiences for each and every person, regardless of their personal or economic circumstance. Riverside is committed to providing assistance for those persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on individual financial situation.

PAYMENT PLAN OPTIONS

For patients who are unable to pay out-of-pocket expenses in full, Riverside Healthcare offers the following options:

- Reasonable payment plans available to all patients
- For hospital services, we offer self-pay discounts for patients without insurance—automatic 72% discount off of gross charges—no application needed
- For physician services, we offer self-pay prompt payment discounts for patients without insurance—automatic 50% discount off of gross charges—no application needed
- Financial assistance including free care or discounted rates based on family size and income—Application and income verification required

Please Note: Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Riverside Healthcare's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

Patients may be asked to provide, if applicable:

- A copy of the family's most recent tax return
- Current bank statements (checking and savings)
- Proof of income for the patient and spouse, if married (2 most recent pay stubs)
- Social security statements; or unemployment stubs
- Current Medicaid or LINK card
- Please Note: Patients indicating they have no income must provide information as to how they are currently supporting themselves
- You may include health care services received at Riverside during the past 12 months as applicable toward your maximum collectible amount

ELIGIBILITY FOR FINANCIAL ASSISTANCE

Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. Patients who are eligible for financial assistance will not be charged more for care than amounts generally billed by the hospital for Medicare patients.

FINANCIAL ASSISTANCE GUIDELINES & ELIGIBILITY DISCOUNTS

The Financial Assistance Guidelines and Eligibility discounts will be provided based on a sliding scale. The Eligibility Criteria discount percentage will be based on the Federal Poverty Guideline calculations updated and published annually by the United States Department of Health and Human Services. An example of eligibility would be a family of 4 with an annual income of less than $31,200. These guidelines can be found at **www.medicaid.gov** keywords "poverty guidelines". A financial assistance application must be completed and may be found on our website at **riversidehealthcare.org** or on the following pages of this informational flyer.

NOTICE: Riverside Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak English, language assistance services, free of charge, are available to you. Call 1-815-933-1671 (TTY: 1-815-935-3323).

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-815-933-1671 (TTY: 1-815-935-3323).

TO LEARN MORE

Learn more about Financial Assistance –
Customer Service (815) 935-7539. Representatives available Monday – Friday from 8:30 a.m. to 5 p.m.
riversidehealthcare.org

RIVERSIDE MEDICAL CENTER

350 North Wall Street
Kankakee, IL 60901
riversidehealthcare.org
Telephone: (815) 935-7539
Fax: (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