Gibson Area Hospital & Health Services
GIBSON GETS IT

Gibson Area Hospital and Health Services
1120 N Melvin Street
Gibson City, IL 60936

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Gibson Area Hospital and Health Services to process your application, all sections must be completed (FRONT AND BACK). Also, we need the following supporting documents submitted with your application if they apply to you:

- Previous year's tax return
- Copy of two (2) most recent pay stubs for all household members' employment income
- Most recent bank statements
- Any other statements you receive from income sources (Social Security, alimony/child support, unemployment, retirement/pension, etc.)

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Applicant Name: _____ Date of Birth: ___/___/___
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (___) _____ Email: _____

The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.

Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Sex: ☐ Male ☐ Female
Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Chinese ☐ Arabic ☐ Russian ☐ Urdu

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card.

☐ Yes ☐ No Insurance Company: _____ Member ID: _____ Group Number: _____

If no, have you applied for Medicaid? ☐ Yes ☐ No
If yes, what is the status of your Medicaid application? ☐ Approved ☐ Denied ☐ Pending

Is your service related to an auto accident? ☐ Yes ☐ No
If yes: Insurance Company:_____ Insurance Phone Number:_____ Insurance Policy Number:_____

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.
- For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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SECTION THREE: INCOME INFORMATION

Please provide any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Wages/Salary		
Self-Employment		
Child Support/Alimony		
Social Security/Retirement		
Rental Income		
Unemployment		
Other Income		

SECTION FOUR: ASSETS INFORMATION

Please list the following

Asset Type	Current Balance - Applicant	Current Balance - Spouse/Other
Bank Account - Savings		
Bank Account - Checking		
Health Savings Account/FSA		

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 medical bill(s). I understand that the information provided may be verified, and I authorize Gibson Area Hospital and Health Services 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 medical bill(s). I grant Gibson Area Hospital and Health Services permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____

Spouse Signature (if applicable): _____ Date: _____

Questions or Concerns

If you have questions or concerns, you may contact Gibson Area Hospital and Health Service's Financial Counseling Department by calling (217)784-2245.

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 at:
Website: https://www.illinoisattorneygeneral.gov/consumers/healthcare.html
Phone Number: 1-877-305-5145 (TTY 1-800-964-3013)