Gibson Area Hospital & Health Services
GIBSON GETS IT
1120 North Melvin Street Gibson City, IL 60936
217-784-4251

GIBSON CARES PROGRAM 2020

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE.

Completing this application and providing all required documents will help GAHHS determine if you can receive free or discounted services or other public programs that can help you pay for your healthcare. 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 date of discharge or receipt of outpatient care.**

To qualify, the services must be medically necessary.

The following are **not** considered medically necessary:

Cosmetic Services, Bariatric-related Services, Elective Services, Services not received at a GAHHS facility, Services deemed non-covered by Medicare, whether or not the patient is covered by Medicare.

Financial assistance is **not** typically available for:

Insurance copayments, failure to comply with reasonable insurance requirements such as obtaining authorizations or referrals, individuals who opt out of insurance coverage, individuals who reside outside of the GAHHS primary service area. ***You will still be asked to pay your insurance copay at the time of service. The availability of financial assistance is not a substitute for personal responsibility.***

You acknowledge that you have 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.

Required Documentation:

Current Tax Return, Current Pay Stubs, Current Bank Statements.

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 continue to page 2 to apply.

GIBSON CARES PROGRAM APPLICATION 2020

To apply: Please complete this form, along with ALL required documentation.

Name: (Last) _____ (First):_____(MI): ____
Home Phone #:_____ Mobile Phone #:_____
Home Address:_____ City:_____ State:____ Zip:_____
Date of Birth:_____ Social Security #: _____
Email: _____
Spouse Name:_____ Spouse DOB:_____
Are you an Illinois resident? _____
Is this service the result of an accident or crime? _____
If YES, please explain: _____
Number of persons in your family/household: _____
Number of exemptions claimed on IRS 1040: _____
Number of Dependents: _____
Name & Age of dependents: _____
_____
Employer:_____Spouse Employer:_____
Address & Phone: _____Address & Phone: _____
_____ _____
Length of employment:_____ Spouse:_____

Please Circle:

Weekly

Bi-Weekly

Monthly

Annually

Other

*Income:	Patient/Guarantor	Spouse/Partner
Wages:	_____	_____
Self-Employment:	_____	_____
Unemployment:	_____	_____
Social Security:	_____	_____
SS Disability:	_____	_____
Veteran Disability:	_____	_____
Veteran pension:	_____	_____
Workers Compensation:	_____	_____
TANF:	_____	_____
Retirement Income:	_____	_____
Child Support/Alimony:	_____	_____
Other: (specify)	_____	_____

Health Insurance: _____
Medicare: _____
Secondary Insurance: _____
Medicare Part D?: _____
Medicaid: _____
Date of application: _____
Veteran's benefits: _____
Other coverage: _____

GIBSON CARES PROGRAM APPLICATION 2020

Bank Name:_____ Checking___ Savings___ CD ___

Assets:

Checking	$_____	
Savings	$_____	
Stocks	$_____	
CD's	$_____	
Mutual Funds	$_____	
Autos	$_____	Year, make, model_____
Real Estate	$_____	
HSA/FSA	$_____	

**Monthly Expenses:

Housing:	$_____	
Utilities:	$_____	
Food:	$_____	
Transportation	$_____	
Child Care	$_____	
Loans	$_____	Specify: _____
Medical	$_____	
Other	$_____	Specify: _____

Documentation of family income can be verified from federal tax returns and pay stubs. Please attach these to this application. The application cannot be processed without this documentation. We also request a current bank statement to verify deposits automatically deposited into your account.

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, including running a credit bureau report. 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: _____

Spouse Signature: _____Date: _____

**If you meet the presumptive eligibility criteria or otherwise presumptive eligible by virtue of the patient's family income, you are not required to complete the application's section on monthly expenses.