

## **Wabash General Hospital Financial Assistance Application Form**

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Wabash General Hospital 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 in one of the following ways:

- To the Business Office in person at 1001 N Market St Mt Carmel, IL
- By mail to 1418 College Drive Mt Carmel, IL 62863 Attention to Financial Assistance
- By electronic mail to [BusinessOffice@wabashgeneral.com](mailto:BusinessOffice@wabashgeneral.com)
- By fax at (618) 263-6467

To apply for free or discounted care applications should be completed within 90 days following the date of discharge or receipt of Out-patient care. If you have any questions please contact the Business Office at (618) 263-6368.

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 [www.IllinoisAttorneyGeneral.gov](http://www.IllinoisAttorneyGeneral.gov). The HealthCare Helpline 1-877-305-5145.

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.

### **Patient Information:**

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Address: \_\_\_\_\_  
\_\_\_\_\_

Patient Telephone Number: \_\_\_\_\_

### **Guarantor Information: (In the case the patient is a minor child.)**

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

Guarantor Telephone Number: \_\_\_\_\_

**Optional Patient Information: Responses or nonresponses by the patient will not have any impact on the outcome of the application.**

Race:

Ethnicity:

Sex:

Preferred Language:

**Family/Household Information:**

1. Number of persons in the patient's family/household. \_\_\_\_\_
2. Number of persons who are dependents of the patient. \_\_\_\_\_
3. Ages of dependents:

**Patient's Family Income and Employment Information:**

(If the patient is a minor, complete Guarantor and Spouse columns if applicable. If the patient is over the age of 18, complete the Patient and Spouse columns if applicable.)

	<b>Patient</b>	<b>Guarantor</b>	<b>Spouse (Partner)</b>
Check the column of who is currently employed.	_____	_____	_____
1. Name of Employer?	_____	_____	_____
<b>List Monthly Income Amounts</b>			
2. Wages (Gross Monthly):	_____	_____	_____
3. Unemployment Compensation	_____	_____	_____
4. Social Security	_____	_____	_____
5. Disability Income	_____	_____	_____
6. Worker's Compensation	_____	_____	_____
7. Temporary Assistance	_____	_____	_____
8. Retirement (Pension)	_____	_____	_____
9. Child Support or Alimony	_____	_____	_____
10. Other Income	_____	_____	_____
<b>Totals</b>	_____	_____	_____

**Include Proof of Income with Application:**

The following are examples of acceptable proof of income used for the determination of financial assistance. It is at the discretion of Wabash General Hospital to determine acceptable proof of income. Acceptable family income documentation shall include any one of the following:

- **Current Federal Income Tax Return (Preferred proof of income)**
- **W-2's**
- **Letter showing current eligibility for assistance**
- **Current Pay Stubs (Last 2 paystubs)**
- **Unemployment Compensation Letter/Notice**
- **Recent LES for Military Personnel**
- **Divorce Decree**
- **Copy of Student Financial Aid Application with determination notice**
- **Food Stamp Document showing current eligibility**
- **Social Security Administration Benefit Letter**
- **Current Bank Statements (Past 3 months)**

**Insurance Benefit Information:**

1. Do you have health insurance coverage? Y or N  
If yes, do you have:  
Medicare? Y or N  
Medicare Part D? Y or N  
Medicare Supplement? Y or N  
Medicaid? Y or N  
Veterans' Benefits? Y or N
  
2. Have you enrolled in the state Medicaid plan or Market Place? Y or N

**Asset and estimated asset value information:**

- 1) Checking:
- 2) Savings:
- 3) Stocks:
- 4) Certificates of deposit:
- 5) Mutual funds:
- 6) Automobiles or other vehicles:
- 7) Real property:
- 8) Health savings/Flexible Spending Account:

If a patient meets the presumptive eligibility criteria established in Section 4500.40 or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

**Monthly expense information and estimated expense figures:**

- 1) Housing:
- 2) Utilities:
- 3) Food:
- 4) Transportation:
- 5) Child care:
- 6) Loans:
- 7) Medical expenses:
- 8) Other expenses:

***Certification Statement:***

I certify that the information in this application is true and correct to the best of my knowledge. 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.

Signature of Patient or Applicant: \_\_\_\_\_

Date \_\_\_\_\_

Effective  
1/1/2026

Uninsured Discount

Family Size	< = 200% 100% Discount	< = 300% Based on gross income Does not qualify
1	0 – 31,920	47,880.00
2	0 – 43,280	64,920.00
3	0 – 54,640	81,960.00
4	0 – 66,000	99,000.00
5	0 – 77,360	116,040.00
6	0 - 88,720	133,080.00
7	0 – 100,080	150,120.00
8	0 – 111,440	167,160.00

For each additional  
Person, Add \$5,680

updated 1/16/26