Carle Community Care
Discount Program

Patient's Medical Record Number

Please mail application and documentation to Carle Patient Accounts, PO Box 6002, Urbana, IL 61803-6002.
If you need help with this application, please call (888)71-CARLE or 217-326-3099.
Additional information can be found at mycarlebill.com.

Application for Carle Community Care Discount Program

Applicant Name:

Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Date of Birth: Social Security # Marital Status:

Employer:

Co-Applicant (*Spouse or legal guardian if minor*):

Date of Birth: Social Security # Marital Status:

Employer:

Do you have medical insurance? ❒ Yes ❒ No Does your co-applicant? ❒ Yes ❒ No

If yes:

Your insurance company name: Policy #

Co-applicant's insurance company name: Policy #

Did you decline taking insurance through your employer? ❒ Yes ❒ No Co-Applicant? ❒ Yes ❒ No

Do you have a Health Spending Account? ❒ Yes ❒ No

Do you have a Medical Flexible Spending Account? ❒ Yes ❒ No

Household Information

Number of people claimed on your taxes: _______

List all dependants (*if more than 4 dependants, please list on separate page*):

Name	Date of Birth	Relationship to Applicant

Assets *(The most recent bank statements including all checking and savings accounts)*

❒ Checking $__________ ❒ Savings $__________ ❒ Certificates of Deposit $__________

❒ Mutual Funds $__________ ❒ Stocks/Bonds $__________

Only one form is necessary per household. *(Please complete and sign other side)*

Income

Required: *Applications without the accepted documentation attached are not able to be processed.*

	Category	Documentation
☐	Federal Income Tax Return	If you did not file taxes, your W2 from any job held or your 1099 for all income received in the previous year.
☐	Applicant's Wages	The last paycheck stub prior to the signature date on this application, from each job held in the past 12 months. Please only send 1 paycheck stub from each job.
☐	Co-Applicant's Wages	The last paycheck stub prior to the signature date on this application, from each job held in the past 12 months. Please only send 1 paycheck stub from each job.
☐	Bank Accounts	Most recent bank or credit union statement(s) for any checking, savings, or investment accounts showing deposits and interest earned.

If applicable: *Applications without the accepted documentation attached are not able to be processed.*

	Category	Accepted Documentation
☐	Self Employment / Farm / Rental Property Income	Ledger of income and expenses for the current year.
☐	Cash assistance from any public programs	Award letter listing amount received in the current year.
☐	Social Security / Disability	Award letter listing amount received in the current year.
☐	Unemployment Benefits	Unemployment compensation benefit award letter for the current year.
☐	Worker's Compensation	Worker's compensation check stub(s) listing the start date and amount received in the current year.
☐	Alimony / Child Support	Divorce decree stating child support or alimony received.
☐	Pensions / Annuities	Letter supplied by system administrator with monthly benefit amount for the current year.
☐	Assistance from Family or Friends	A notarized statement from family or friends explaining any financial help that they give you.
☐	Other	If proof of income is not provided, a written explanation is required.

If you have any additional documents that may help Carle make a determination regarding your application, please include with this application.

I understand that all of the information given will be confirmed by Carle. I also understand that false information will result in a denial of the Community Care Discount Program application and that I will owe the charges for the services provided. I also understand that I may re-apply in six (6) months if my financial situation changes. I understand that if I am approved the discount is good for 1 year from the date the application is approved by Carle.

____________________________________ ____________________

Applicant Signature (required) Date

Carle