Carle Foundation Hospital
Patient Accounting
611 West Park Street, Urbana, Illinois, 61801 Phone: 217-326-2900 Fax: 217-326-2986 TTY: 217-326-4000

Patient's Social Security # ☐☐☐-☐☐-☐☐☐☐

Application for Carle Foundation Hospital Uninsured Discount

If you need any help with this form, please call 217-326-2900.

Patient Name ____________________ **Medical Record #** ☐☐☐☐☐☐☐

Name of person responsible for paying account ____________________

Address ____________________ **Phone #** __________

Employer ____________________

Spouse's Name ____________________

Spouse's Employer ____________________

Bank Name(s) ____________________

(Please check all that apply and include balances)

Assets:

☐ **Checking $**__________ ☐ **Savings $**__________ ☐ **CDs (Certificates of Deposit) $**__________

☐ **Mutual Funds/Stocks/Bonds $**__________

Income: Please check boxes for items that apply and give the amounts received during the past 12 months.

☐	Your wages	$ ___ , ___ . 00
☐	Spouse's wages	$ ___ , ___ . 00
☐	Farm or Self-Employment Income	$ ___ , ___ . 00
☐	Public Assistance	$ ___ , ___ . 00
☐	Social Security/Disability	$ ___ , ___ . 00
☐	Unemployment/Worker's Compensation Benefits	$ ___ , ___ . 00
☐	Alimony/Child Support	$ ___ , ___ . 00
☐	Pensions/Annuities	$ ___ , ___ . 00
☐	Dividends/Interest/Rent	$ ___ , ___ . 00
☐	Income from family or friends	$ ___ , ___ . 00
☐	Income from other sources	$ ___ , ___ . 00

Total gross income from all sources for the past 12 months. $___ , ___ **.00**

(Please complete and sign other side)

Number of people claimed on your tax return. __________

Number of children aged 18 and under. __________

Expenses:

- ☐ Your child support payments $, . 00
- ☐ Your spouse's child support payments $ |_|_|_| ,|_|_|_|. 00

Copies of one of the following forms <u>must</u> be returned with your application (if applicable):

Most recent 1040 tax forms.

Copy of most recent W-2 form and 1099 forms

Copies of two most recent pay stubs

Written income verification from an employer if paid in cash

One of the following forms of verification of Illinois residency <u>must</u> be returned with your application:

A valid state-issued identification card

A recent residential utility bill

A lease agreement

A vehicle registration card

A voter registration card

Mail addressed to the patient at an Illinois address from a government source

A statement from a family member who resides at the same address and a copy of verification of residency

A letter from a homeless shelter, transitional house, or similar facility verifying residency

Copies of the following forms <u>must</u> be returned with your application (if applicable):

Copies of bank statements

Verification of asset values

If you can't provide proof of an asset value, please include a written statement of its value.

This application must be returned within 60 days of service being provided. Copies of the requested forms must be turned in with application or mailed to the above address within thirty(30) days. Applications without copies of the required forms and signatures cannot be considered.

I understand that all of the information given will be confirmed by Carle Foundation Hospital. I also understand that false information will result in a denial of the Uninsured Discount application and that I will owe the charges for the services provided.

Applicant Signature ____ **Date** _________________