



Carle Foundation Hospital

Patient's Social Security # [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ][ ]

Patient Accounting

611 West Park Street, Urbana, Illinois, 61801 Phone: 217-326-2900 Fax: 217-344-8047

Application for Carle Foundation Community Care Discount Program
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 \_\_\_\_\_

Insurance Name \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Phone # \_\_\_\_\_

Bank Name(s) \_\_\_\_\_

(Please check all that apply and include balances)

Assets:

[ ] Checking \$ \_\_\_\_\_ [ ] Savings \$ \_\_\_\_\_ [ ] 401k/403b \$ \_\_\_\_\_

[ ] CDs (Certificates of Deposit) \$ \_\_\_\_\_ [ ] IRA(s) \$ \_\_\_\_\_

[ ] 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
[ ] 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.**

\_\_\_\_\_

**All outstanding medical expenses (please list provider(s) and amount(s) owed)**

<b>Provider</b>	<b>Amount</b>

**Copies of the following forms must be returned with your application (if applicable):**

Most recent tax forms.

Most recent check stub(s) from all jobs held in the past 12 months.

Unemployment check stub listing start date and amount.

Divorce decree stating child support or alimony received.

Your most recent bank statement(s).

Letter from public programs (Social Security, Veterans, Public Aid) listing amount received.

Award letter for scholarship or grant.

A statement from family or friends explaining any financial help that they give you.

If you can't provide proof of an income source, please attach an explanation as to why.

**This application must be returned within the next fourteen (14) days. Copies of income forms must be turned in with application or mailed to the above address within fourteen (14) days.**

**Applications without copies of income forms and signatures cannot be considered.**

**If your financial situation changes for any reason, please do not hesitate to re-apply after six (6) months from date of application.**

I understand that all of the information given will be confirmed by Carle Foundation Hospital or its related businesses. 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.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_