



Financial Assistance Program (FAP) Summary

Harrisburg Medical Center is committed to serving our community and grants financial assistance, in the form of free or discounted care, to patients who meet the criteria of the Financial Assistance Program. The FAP provides assistance to individuals who are uninsured or under-insured and have medical bills for care billed by Harrisburg Medical Center at the following locations:

- Harrisburg Medical Center, Inc.
- Harrisburg Medical Center Physician billing for hospitalists , emergency room providers, certified registered nurse anesthetists and EKG/stress tests provider billing Mulberry Center
- Mulberry Center
- HMC Orthopaedic Clinic
- HMC Specialty Clinic
- Eldorado Primary Care
- Equality Family Practice
- HMC Clinic at Harrisburg
- HMC Clinic at Marion
- Galatia Primary Care

Individuals meeting the Program criteria may be approved for a full or partial reduction of their hospital bill and will not be expected to pay more for emergency or other medically necessary care than the amounts generally billed to third party payors.

Providers delivering care in the hospital which are not covered by the financial assistance policy are cardiologists, gastroenterologists, pediatric cardiologists, nephrologists, obstetricians and gynecologists, nephrologist, neurologist/sleep medicine, oncologist/hematologist, ophthalmologists, pathologists, podiatrists, psychiatrists, pulmonologists, urologists, radiologists, surgeons not employed by the hospital, and family practice physicians not employed by the hospital. To request listing by provider name contact the Financial Counselor at (618)253-7671 ext. 10251.

To apply for the Financial Assistance Program or to learn more about the Financial Assistance Program:

- Visit our website at www.harrisburgmc.com.
- Visit our Business Office, Monday thru Friday, 8:00 am – 4:30 pm at
100 Dr. Warren Tuttle Dr.
Harrisburg IL 62946
- Call a Financial Counselor at (618)253-7671 ext. 10251

PART C – HOUSEHOLD INFORMATION

List the number of persons in the patient’s family/household: _____

List the Ages of Dependents (not including self) that you claimed on your last tax return.

- Ages: _____

PART D – GROSS INCOME

Total Family Income PER MONTH

\$ _____ Patient/Responsible Party Salary (GROSS)
 \$ _____ Spouse/Parent Salary (GROSS)
 \$ _____ Social Security Benefits
 \$ _____ Pension (including VA pension)
 \$ _____ Disability Benefits
 \$ _____ SSI/TANF
 \$ _____ Food Stamps
 \$ _____ Alimony received
 \$ _____ Rental Income received
 \$ _____ Business Income
 \$ _____ Unemployment benefits
 \$ _____ Workman’s Compensation benefits
 \$ _____ General Assistance
 \$ _____ Other (Please explain)
 \$ _____ TOTAL MONTHLY INCOME

EXPENSES

Total Family Expenses PER MONTH

\$ _____ Mortgage Payment/Rent
 \$ _____ Utilities (Gas, water, elect, phone)
 \$ _____ Monthly Insurance Premiums
 \$ _____ Total Vehicle Payments
 \$ _____ Cable or Direct TV/Internet
 \$ _____ Medications
 \$ _____ Food
 \$ _____ Monthly medical payments
 *****List in detail in Part E
 \$ _____ Credit card payments
 \$ _____ Loan payments (not vehicles)
 *****List in detail in Part E
 \$ _____ Childcare/Daycare
 \$ _____ Child Support (Provide proof)
 \$ _____ TOTAL MONTHLY EXPENSES

PART E – FINANCIAL OBLIGATIONS/LOANS (Financial Obligations include medical, credit cards, loans, etc.)

| <u>Name of Creditor</u> | <u>Address</u> | <u>Total Amount Owed</u> | <u>Monthly Payment</u> |
|-------------------------|----------------|--------------------------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PART F – SPECIAL SITUATIONS *** If you did not file a tax return last year please indicate the reason below and the last year you did file a return.*** If you do not have a checking or savings account, please indicate this below.

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. 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/Responsible Party

 Date