HORIZON HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

How did you hear about our program? (family member, friend, Dr., etc)_______________________

Applicant's Name____DOB___________

Applicant's Address____Phone#__________
Street/PO Box# City State Zip code

Applicant's Employer____

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name____DOB___________

Spouse's Employer____

Do you have current Medicare, Medicaid or health insurance? ___________

Number of persons in household included in your tax return_____ (list below)

Name________________________________ DOB______________ Insurance________________

Name________________________________ DOB______________ Insurance________________

Name________________________________ DOB______________ Insurance________________

Name________________________________ DOB______________ Insurance________________

Name________________________________ DOB______________ Insurance________________

TOTAL FAMILY GROSS INCOME

Please check boxes for items that apply and provide proof of amounts received for the past 13 weeks.

- ☐ **Applicant's wages: The last 13 check stubs if paid weekly or last 7 if paid every other week.**
- ☐ **Spouse's wages: The last 13 check stubs if paid weekly or last 7 if paid every other week.**
- ☐ **Alimony/child support: Copy of the court order or copy of last three months received.**
- ☐ **Farm or self-employment income: Copy of most recent tax return and list of income received in the last 3 months.**
- ☐ **Social Security/Disability/Pensions: Copy of benefit sheet showing monthly amount received**
- ☐ **Unemployment/Workers compensation: Copy of weekly benefit amount (WBA) form showing last day worked and gross benefit amount or the last 13 check stubs if paid weekly, last 7 if paid every other week, or last 3 if paid monthly.**
- ☐ **Public Assistance (cash or food stamps): Copy of amount received from Public Aid office.**
- ☐ **No income: A signed letter from family or friends explaining any money or help they give you. Include how often it is given. Example: on a weekly, monthly, yearly basis.**

TO FINISH YOUR APPLICATION, WE MAY NEED MORE INFORMATION

I certify that everything stated in this application and all attachments are true and complete. I understand that I must update this information at the request of Horizon Health. The falsification of data may result in the reversal of any discount. I authorize Horizon Health to check my credit and employment history and I will answer any questions required.

Applicant's Signature: ______________________________ Spouse: ______________________________
Date: _____________

HORIZON HEALTH
“Help us, Help you”
Financial Assistance Program

Horizon Health knows the financial problems that families face due to unplanned healthcare costs. Because we care about our community and its people, we will offer financial assistance to families who may not be able to pay for their healthcare.

What is Financial Assistance?

Financial assistance is discounted healthcare provided by Horizon Health. It is available to residents of our service area in Illinois* who apply and qualify based upon the family’s gross income (before taxes). Financial Assistance is for patients who do not qualify for other assistance programs such as Illinois Public Aid. Health services must be medically necessary as determined by the attending physician, which includes comprehensive primary care, to be eligible for Financial Assistance.

Veterans: Financial Assistance is only available for services approved by the VA to be provided by Horizon Health.

How do I apply?

Please complete the application on the back side of this form. The completed application and the required proof should be returned to Horizon Health. A Financial Assistance Coordinator is available to answer your questions by calling the Business Office at (217) 466-4257. **Please return completed application to 721 E Court St. Paris IL 61944, Attn: Kris**. For more information visit www.myhorizonhealth.org

How do I know if I qualify for Financial Assistance?

We will use the income table below to see if you qualify. If your income falls within the guidelines listed below, the Financial Assistance Coordinator will help you see if you qualify for either discounted or free healthcare services.

Discount Level*	100%	90%	80%	70%	60%	50%
Family Size						
1	19,320	21,896	24,472	27,048	25,760	32,200
2	26,130	29,614	33,098	36,582	34,840	43,550
3	32,940	37,332	41,724	46,116	43,920	54,900
4	39,750	45,050	50,350	55,650	53,000	66,250
5	46,560	52,768	58,976	65,184	62,080	77,600
6	53,370	60,486	67,602	74,718	71,160	88,950
7	60,180	68,204	76,228	84,252	80,240	100,300
8	66,900	75,820	84,740	93,660	89,200	111,500
Each Additional	6,810	7,264	7,718	8,172	8,626	9,080

Example 1: Family of 4 with an income level of $30,000 qualifies for 100% discount.
Example 2: Family of 2 with an income level of $29,500 qualifies for 90% discount.

Horizon Health does have the right to change or take away approval if we receive information that shows a change in the family’s financial situation or if the family moves out of our service area.
****Our service area includes Edgar County and Clark County, and areas outside of Edgar County with the following zip codes: 61846, 61850, 61870, 61876, 61912, 61920 (Bushton and Rardin only), 61924, 61930, 61942, 61943***
If you do not reside in our service area, please contact other hospitals in your area to inquire about their assistance programs.

Application Issue Date 01/22/2020