HORIZON HEALTH
FINANCIAL ASSISTANCE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Horizon Health determine if you can receive free or discounted services, or if you might qualify for other public programs that can help pay for your healthcare. Please submit this application to the hospital. IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs. Financial Assistance is available to residents of our service area in Illinois.*

Please complete this application and submit to apply for free or discounted care. Completed applications can be submitted as follows:

- In person to the Financial Assistance Coordinator at Horizon Health, 721 E Court St, Paris, IL 61944
- Online by visiting myhorizonhealth.org
- By fax to 217-465-4246 Attn: Financial Assistance Coordinator
- By mail to: Horizon Health, Attn: Financial Assistance Coordinator, 721 E Court St, Paris, IL 61944

If you have any questions or concerns, please contact the Financial Assistance Coordinator at 217-466-4257.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

OPTIONAL: In accordance with the Illinois Hospital Uninsured Patient Discount Act, we are required to ask the following. Completion is optional. Responses or nonresponses will not have any impact on the outcome of the application.

RACE: ___White ___Black or African American___Asian___Other

ETHNICITY: _____Non-Hispanic_____Hispanic

Gender at birth:_____Male_____Female

Preferred Gender:_____Male_____Female

PREFERRED LANGUAGE: _____

ANNUAL FAMILY INCOME 2022

Discount Level*	100%	90%	80%	70%	60%	50%
Family Size						
1	20,385	23,103	25,821	28,539	31,257	33,975
2	27,465	31,127	34,789	38,451	42,113	45,775
3	34,545	39,151	43,757	48,363	52,969	57,575
4	41,625	47,175	52,725	58,275	63,825	69,375
5	48,705	55,199	61,693	68,187	74,681	81,175
6	55,785	63,223	70,661	78,099	85,537	92,975
7	62,865	71,247	79,629	88,011	96,393	104,775
8	69,945	79,271	88,597	97,923	107,249	116,575
Each Additional	7,080	8,024	8,968	9,912	10,856	11,800

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.

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, 61924, 61930, 61942, 61943, Bushton, and Rardin.

If you do not reside in our service area, please contact other hospitals in your area to inquire about their assistance programs.

HORIZON HEALTH FINANCIAL ASSISTANCE APPLICATION

Applicant's Name_____**DOB**_____

Applicant's Address_____**Phone#**_____
Street/PO Box# **City** **State** **Zip code**

Employer:_____ **How long?**_____**Full-time**__**Part-time**__

How often paid (Please circle) weekly bi-weekly monthly other (please explain) _____

Primary Insurance Name:_____**Secondary Insurance Name:**_____

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name_____**DOB**_____**Phone#**_____

Employer:_____**How long?**_____ **Full-time**__**Part-time**__

How often paid (Please circle) weekly bi-weekly monthly other (please explain) _____

Primary Insurance Name:_____**Secondary Insurance Name:**_____

Number of persons in household included on your tax return: _____

Please provide tax returns as proof of family size (not needed if applicant and spouse only).

Dependents name:_____ **DOB:**_____

Dependents name:_____ **DOB:**_____

Has anyone in your household ever served in the military or as a first responder, past or present? Y N

GROSS MONTHLY FAMILY INCOME: Includes that of the applicant and spouse from all sources. Copies of the following forms (if applicable) must be submitted with your application:

- **Bank statements: Most recent bank statement.**
- **Applicant and spouses' wages: Most recent check stub(s). Last 13 if paid weekly; 7 if paid biweekly.**
- **Social Security/Disability/Pensions: Copy of benefit sheet showing monthly amount received.**
- **Alimony/child support: Copy of court order showing the monthly amount received (or paid).**
- **Farm or Self-employment income: Complete copy of tax returns including W2's if applicable.**
- **Unemployment/Workers compensation: Copy of weekly benefit amount form showing last day worked and gross benefit amount, or last 13 check stubs if paid weekly; 7 if paid bi-weekly.**
- **Public Assistance (cash or food stamps): Copy of notice from Medicaid showing amount received.**
- **No Income: A signed letter from family or friends explaining any money or help they give you to make ends meet. How often and how much.**
- **Certification:**

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.

Applicant's Signature: _____ **Spouse:** _____ **Date:** _____