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.

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.

ANNUAL FAMILY INCOME-EFFECTIVE February 1, 2019

Discount Level*	100%	90%	80%	70%	60%	50%	40%	30%	20%
Family Size									
1	18,735	19,984	21,233	22,482	23,731	24,980	26,229	27,478	31,225
2	25,365	27,056	28,747	30,438	32,129	33,820	35,511	37,202	42,275
3	31,995	34,128	36,261	38,394	40,527	42,660	44,793	46,926	53,325
4	38,625	41,200	43,775	46,350	48,925	51,500	54,075	56,650	64,375
5	45,255	48,272	51,289	54,306	57,323	60,340	63,357	66,374	75,425
6	51,885	55,344	58,803	62,262	65,721	69,180	72,639	76,098	86,475
7	58,515	62,416	66,317	70,218	74,119	78,020	81,921	85,822	97,525
8	65,145	69,488	73,831	78,174	82,517	86,860	91,203	95,546	108,575
Each Additional	6,630	7,072	7,514	7,956	8,398	8,840	9,282	9,724	11,050

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 70% 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 areas outside of Edgar County that have the following zip codes: 61850, 61870, 61876, 61912, 61920 (Bushton and Rardin only), 61924, 61930, 61943, 62420, 62423, 62441, 62442, and 62474

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 02/01/2019

HORIZON HEALTH
ILLINOIS MEDICAID SCREENING FORM

BE SURE TO ANSWER EACH QUESTION BEFORE SIGNING

1. Do you have a child or children under 19 years of age living with you that is a blood relative?
   - Example: Son, Grandchild, Niece

2. Are you 65 years of age or older?

3. Are you disabled?

4. Are you legally blind?

If you answered YES to any of the above questions: You MUST apply for Medicaid prior to Financial Assistance. Therefore, we cannot process your application for financial assistance until you apply for state assistance/Medicaid. You may obtain a guide to applying for Medicaid from our office staff. You can obtain a Medicaid application from your local public aid office. Medicaid ID # (if approved) or a denial letter MUST be provided to our office in order to continue the financial assistance process.

If you answered NO to the first 4 questions, you MAY still be eligible for state assistance, aka: IL Medicaid expansion:
The Affordable Care Act (ACA) made it possible for Illinois to expand Medicaid to cover non-disabled adults, ages 19-64, without children. Income must be at or below 138% of the federal poverty level. This is an approximate monthly income of $1,436/individual or $1,945/couple.

****If you apply for Financial Assistance and we determine you may qualify for state assistance, either by answering yes to any of the 4 questions or based on income alone, you will not be eligible for Financial Assistance until you apply for state assistance and receive an approval or denial letter.****

Coordinator Signature and Date _____

Patient Signature and Date _____