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 2026

Discount Level*	100%	90%	80%	70%	60%	50%
Family Size						
1	23,940	27,132	30,324	33,516	36,708	39,900
2	32,460	36,788	41,116	45,444	49,772	54,100
3	40,980	46,444	51,908	57,372	62,836	68,300
4	49,500	56,100	62,700	69,300	75,900	82,500
5	58,020	65,756	73,492	81,228	88,964	96,700
6	66,540	75,412	84,284	93,156	102,028	110,900
7	75,060	85,068	95,076	105,084	115,092	125,100
8	83,580	94,724	105,868	117,012	128,156	139,300
Each Additional	8,520	9,656	10,792	11,928	13,064	14,200

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 $32,500 qualifies for 90% discount.

Our service area includes all of Edgar and Clark County, and the following zip codes in the surrounding area: 61930, 61942, 61912, 61943, 61920 (Bushton and Rardin) only, 61846, 61850, 61870, 61810, 61817, 61833, 61841, 61844, 61857, 61858, 61883, 61876. 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 twice 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 twice monthly other (please explain)

Primary Insurance Name:_____Secondary Insurance Name:_____

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

If dependents are listed, provide proof of family size with a copy of the most recent tax return.

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

Do you have any outstanding Horizon Health EMS (Ambulance) bills? Y N

Documentation to be provided along with the completed application:

- **Bank statements: Three** most recent bank statements(all pages) from all accounts including savings.

AND all of the following that are applicable:

- **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.
- **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.

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:** _____

Illinois Medicaid Screening

The following information is used to determine if we think you might qualify for Medicaid benefits. If your income falls within the Medicaid guidelines for your family size we will ask you to apply for Medicaid before further financial assistance is considered. For more information or to apply for Medicaid, call your local DHS office, or visit *abe.illinois.gov*.

Applicants over 65, blind, or disabled (AABD program)must also meet a resource limit. Many times, the beneficiary may become a Spenddown case due to lower income standard (100% FPL versus 138%) and the AABD resource limit ($2000/single; $3000/couple).

You may obtain a guide to applying for Medicaid from our office staff, or by calling 217-466-4257. Once you receive a Notice of Decision from Medicaid, please provide us a copy so we can finalize your application for financial assistance.

2026 Annual Household Income Limits (before taxes) 138% of Federal Poverty Level
ACA Adults (age 19-64) not yet eligible for Medicare

	Maximum Income Level (Per Year)	
	Federal Poverty Level	
Household Size*	**100%**	**138%**
1	$15,960	$22,025
2	$21,640	$29,863
3	$27,320	$37,702
4	$33,000	$45,540
5	$38,680	$53,378
6	$44,360	$61,217
7	$50,040	$69,055
8	$55,720	$76,894

*For households with more than eight people, add $5680 per additional person. Always check with the appropriate managing agency to ensure the most accurate guidelines.

PATIENT FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

HOUSEHOLD INFORMATION:

Number of persons in the patient's family/household shall exclude any non-minor children, living at home but not claimed on the parents' tax return. Number of dependents includes those that are claimed on your tax return. You will be required to submit a copy of your most recent tax return to support the number of claimed household dependents. A non-minor child still living in the parent's household, and not claimed on the parent's tax return, shall apply for financial need separately based on his/her own income and not that of the parents. If the non-minor child is claimed on the parent's tax return, then the parents' income should be factored in to the household income for financial need determination.

PUBLIC AID (MEDICAID) ASSISTANCE:

Applicants who are determined to be potentially eligible for Medicaid coverage are required to apply for public aid assistance to determine eligibility under the State Medicaid system prior to determining eligibility for the Uninsured Patient Discount and Financial Assistance Programs. Additional information, including names of dependents, may be necessary in order to assist in determining your Medicaid eligibility and completing a Medicaid application. If you need assistance obtaining and completing an application, the Financial Assistance Coordinator (217-466-4257), or Patient Advocate (217-466-4522) at Horizon Health can assist you.

INDEPENDENT PHYSICIAN FEES ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE:

Independent physicians providing services at Horizon Health, including but not limited to, some surgeons, radiologists, pathologists, and specialty clinic physicians, who bill for their services separately. This Hospital Financial Assistance application does not cover nor apply to fees charged by those independent physicians.

ATTACHMENTS: If you do not have access to a copier, feel free to bring in your original supporting documentation when returning this completed application and we will be happy to make the necessary copies for you.

NOTIFICATION AND APPROVALS:

Notification of approval or request for additional information will be provided to you within approximately 2 weeks of returning the application with all completed documentation. Upon expiration of the approval, applicant will be asked to complete a new application form to update on the current financial status and any changes thereof.

COMPLAINTS:

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process maybe reported to the Health Care Bureau of the Illinois Attorney General. You can call 1-877-305- 5145 (TTY 1-800-964-3013) or visit the following website https://www.illinoisattorneygeneral.gov/consumers/healthcare.html.