SIU MEDICINE
CENTER FOR FAMILY MEDICINE

SIU Center for Family Medicine
Financial Application

Springfield • Quincy • Jacksonville • Lincoln • Decatur • Carbondale • Taylorville

Integrating Medical, Behavioral and Dental Health

Responsible Party Information Are you head of household (HoH)? ( ) Yes ( ) No			
Name (First, Middle, Last)		**Date of Birth**	**Social Security #**
Home Address	**City** **State**	**Home Phone #**	**Cell Phone #**
Employer's Name	**Job Title**	**Date of Employment**	**Employer's Phone #**

Spouse's Information (If Applicable)			
Name (First, Middle, Last)		**Date of Birth**	[redacted]
Employer's Name	**Job Title**	**Date of Employment**	**Employer's Phone #**

List Dependents (If Different From Tax Return, Please Explain)

Name	**Date of Birth**	**Relationship**

Have you applied for Public Aid? YES NO If Public Aid denied you, you must provide a copy of the denial.

Income: You must provide documentation for each item and provide a copy of your federal tax return or paycheck stubs for the last 3 months

Responsible Party Income			**Spouse's Income (If Applicable)**		
Wages (Monthly)	$		Wages (Monthly)	$	
Farm/Self-Employment	$		Farm/Self-Employment	$	
Public Assistance	$		Public Assistance	$	
Social Security/Disability	$		Social Security/Disability	$	
Unemployment/Work comp	$	Date of Unemployment	Unemployment/Work comp	$	Date of Unemployment
Alimony/Child Support	$		Alimony/Child Support Received	$	
Annuities/Dividends/Interest	$		Annuities/Dividends/Interest	$	
Pension	$		Pension	$	
Income From Other Sources	$		Income From Other Sources	$	
TOTAL INCOME FOR PAST 12 MONTHS	$$		**TOTAL INCOME FOR PAST 12 MONTHS**	$$	

If applicant has no income, he/she is required to provide a dated and signed statement from the person(s) who provides their financial support.

Assets:

Checking $_____ Savings $_____ 401K $_____ CDs $_____ IRA $_____ Mutual Funds/Stocks/Bonds $_____

REQUIRED DATA: The Federal Government asks us to collect the following information – thank you in advance for complying.

Please indicate your educational level: _____

Please check if you are a Veteran: ( ) Yes, I am a veteran

Please check one of the following:
( ) Not Homeless ( ) Homeless
( ) Migrant Worker ( ) Other _____

Please check a race and ethnicity:
Race: ( ) Black/African American ( ) White ( ) Asian
( ) Native Hawaiian ( ) Other Pacific Islander ( ) American India/Alaska Native
( ) Other ( ) Refuse to Answer ( ) _____

Ethnicity: ( ) Hispanic / Latino ( ) Not Hispanic ( ) Refuse to Answer

REQUIRED DATA: Public Housing Information

Are you currently living in public housing? ( ) Yes ( ) No

If yes, please check the type of public housing dwelling you live in:

( ) Duplex ( ) High Rise ( ) Low Rise
( ) Single Dwelling (Section 8)

I understand this information will be used only for determination of financial responsibility for my charges at SIU Center for Family Medicine and will be kept confidential. My signature authorizes SIU Center for Family Medicine to verify any information furnished on this form.

To the best of my knowledge, the information provided above is true and correct.

Patient/Signature (if adult): _____ Date: _____

Responsible party signature: _____ Date: _____

Signature of person completing form, if different from patient: _____

PLEASE RETURN THIS COMPLETED APPLICATION AND ALL REQUESTED DOCUMENTATION WITHIN 15 DAYS.
IF THE APPROPRIATE DOCUMENTATION IS NOT ATTACHED, YOUR APPLICATION WILL BE RETURNED TO YOU FOR COMPLETION.

SIU Center for Family Medicine
DISPOSITION, RECOMMENDATION AND APPROVAL

For Office Use Only

Pt Name: _____

_____

MRN#: _____

To be completed by office staff only:

Application Received by: _____
Signature of Financial Counselor

Application Received Date: _____ **Recommendation Date:** _____

Disposition of Application and Recommendation:

Per cent of FPD: _____ **Level:** _____

RECOMMENDED BEST OPTION

( ) Qualifies for Medicaid **( ) Qualifies for Medicare**

( ) Refuses to apply for Medicaid

FQHC Level _____ (reference chart below)

2020 ANNUAL FEDERAL POVERTY LEVEL (FPL) GUIDELINES						
FAMILY SIZE -- Members in Household	PERCENT OF FPL					
	2020 FPL	100% or Less	101%-138%	139%-150%	151%-175%	176%-200%
Annual income displayed is highest possible in each category in order to qualify						
1	$12,760	$12,760	$17,609	$19,140	$22,330	$25,520
2	$17,240	$17,240	$23,791	$25,860	$30,170	$34,480
3	$21,720	$21,720	$29,974	$32,580	$38,010	$43,440
4	$26,200	$26,200	$36,156	$39,300	$45,850	$52,400
5	$30,680	$30,680	$42,338	$46,020	$53,690	$61,360
6	$35,160	$35,160	$48,521	$52,740	$61,530	$70,320
7	$39,640	$39,640	$54,703	$59,460	$69,370	$79,280
8	$44,120	$44,120	$60,886	$66,180	$77,210	$88,240
Each add'l family member > 8	$5,600	$5,600	$5,600	$5,600	$5,600	$5,600

Sliding Fee Scale		Nominal Fee				
MEDICAL & BEHAVIORAL		**Level 0 $5**	**Level 1 $10**	**Level 2 $15**	**Level 3 $20**	**Level 4 $25**
DENTAL		**See attached for specific procedure cost**	**See attached for specific procedure cost**	**See attached for specific procedure cost**	**See attached for specific procedure cost**	**See attached for specific procedure cost**

If between applying during State Exchange Sign-up Period:

( ) Above 138% of FPL but under or at 200% FPL – Qualifies for State Exchange with Subsidy

( ) Above 200% FPL – Qualifies for State Exchange but no subsidy

FOR REFERENCE ONLY – Patient Assistance Discount Schedule - Adjusted Gross Income (Before IRA/KEOUGH/SEP Deductions)

Recommended by: _____ Date_____

Reviewed and Approved by: _____ Date_____

Revised and Effective 2.27.20