Financial Application

SIU Medicine, PO Box 19651, Springfield, Illinois 62794-9651

Responsible Party Information			
Name (First, Middle, Last)		**Date of Birth**	**Account #**
Home Address **City** **State**		**Home Phone #**	
Employer's Name	**Job Title**	**Date of Employment**	**Employer's Phone #**
Spouse's Information (If Applicable)			
Name (First, Middle, Last)		**Date of Birth**	
Employer's Name	**Job Title**	**Date of Employment**	**Employer's Phone #**

For Office Use Only

Payments $_____

Approved % _____

Approved Thru _____

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 income tax return.**					
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 $_____

Monthly Obligations:				**Creditors:** Hospitals, Doctor/Clinic, Bank Loans, Credit Cards, etc.		
Rent/House Payment	$			**Name**	**Balance $**	**Monthly Payment $**
Light and Heat	$				$	$
Garbage Removal	$				$	$
Water and Sewer	$				$	$
Telephone/Cell Phone	$				$	$
Cable TV	$				$	$
Medicine Expenses	$				$	$
Car Payment	$				$	$
Car Insurance (Monthly)	$				$	$
Life Insurance	$				$	$
Food & Household Supplies	$				$	$
Miscellaneous	$	Explain			$	$
TOTAL MONTHLY OBLIGATIONS	$$			**TOTAL BALANCE AND MONTHLY PAYMENTS TO CREDITORS**	$$	$$

I understand this information will be used only for determination of financial responsibility for my charges at SIU Medicine, and will be kept confidential. My signature authorizes SIU 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.

FOR REFERENCE ONLY

PATIENT CARE ASSISTANCE DISCOUNT SCHEDULE FOR 2021 – ADJUSTED GROSS INCOME (BEFORE IRA/KEOUGH/SEP DEDUCTIONS)

Family Size		100 % Discount (125% Federal Poverty Level FPL)	90% Discount (150% FPL)	75% Discount (175% FPL)	50% Discount (200% to 400% FPL)	
1		$16,988	$20,385	$23,783	$27,180	$54,360
2		$22,888	$27,465	$32,043	$36,620	$73,240
3		$28,788	$34,545	$40,303	$46,060	$92,120
4		$34,688	$41,625	$48,563	$55,500	$111,000
5		$40,588	$48,705	$56,823	$64,940	$129,880
6		$46,488	$55,785	$65,083	$74,380	$148,760
7		$52,388	$62,865	$73,343	$83,820	$167,640
8		$58,288	$69,945	$81,603	$93,260	$186,520
For each additional person, add		*$5,900*	*$7,080*	*$8,260*	*$9,440*	*$18,880*
		If discount is 100%, patient must pay either the remaining 5% or the minimum payment identified below - whichever is higher.	If discount is 90%, patient must pay either the remaining 10% or the minimum payment identified below - whichever is higher.	If discount is 75%, patient must pay either the remaining 25% or the minimum payment identified below - whichever is higher.	If discount is 50%, patient must pay either the remaining 50% or the minimum payment identified below - whichever is higher.	
Minimum Guarantor Responsi-bility (applied before discount)	Primary Care	New - $40; Return - $20	New - $40; Return - $20	New - $40; Return - $20	New - $40; Return - $20	
	Specialty	New - $40; Return - $20	New - $40; Return - $20	New - $40; Return - $20	New - $40; Return - $20	
	Psychiatry	New - $75; Return - $45	New - $75; Return - $45	New - $75; Return - $45	New - $75; Return - $45	

Rev: 01-27-21

Full Form Revised 3/2/2022