SIU Center for Family Medicine
Financial Application

Springfield Quincy Jacksonville Lincoln Decatur Carbondale Taylorville Pittsfield

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	
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)

2021 ANNUAL FEDERAL POVERTY LEVEL (FPL) GUIDELINES						
FAMILY SIZE -- Members in Household	PERCENT OF FPL					
	2021 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	$12,880	$12,880	$17,774	$19,320	$22,540	$25,760
2	$17,420	$17,420	$24,040	$26,130	$30,485	$34,840
3	$21,960	$21,960	$30,305	$32,940	$38,430	$43,920
4	$26,500	$26,500	$36,570	$39,750	$46,375	$53,000
5	$31,040	$31,040	$42,835	$46,560	$54,320	$62,080
6	$35,580	$35,580	$49,100	$53,370	$62,265	$71,160
7	$40,120	$40,120	$55,366	$60,180	$70,210	$80,240
8	$44,660	$44,660	$61,631	$66,990	$78,155	$89,320
Each add'l family member > 8	$4,540	$4,540	$4,540	$4,540	$4,540	$4,540

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 2.25.21