



5409 North Knoxville Avenue
Peoria, IL 61614
Phone 309-691-1083
Email patientaccounts@proctor.org

Dear Patient and Guarantor:

Thank you for your interest in Proctor Hospital's Financial Assistance Program. Proctor Hospital, owned and operated by Proctor Health Care Incorporated, is committed to providing quality healthcare to its patients and the surrounding community regardless of their ability to pay. This is part of the Hospital's Mission and Corporate Purpose. Our commitment includes providing healthcare to those who may lack the financial means to pay for these services. This policy will insure that Proctor Hospital identifies those who may need assistance in the form of charity.

Eligibility for charity consideration is determined solely on the information provided to the Hospital on the Financial Assistance Worksheet and verified by our staff. Patients must identify and assign all insurance benefits to the Hospital as well as assist in the maximization of reimbursement by all insurance and liability policy benefits. Patients (or immediate family) must provide financial information regarding income and assets in order to determine patient financial responsibility for any account balances after resolution of all insurance benefits. This material is kept confidential and is used only for verifying financial information for the Financial Assistance Program.

In order to proceed with this process, please complete the attached Financial Assistance Worksheet and return it with the requested documentation within 30 days to Proctor Hospital Patient Accounting, PO BOX 3336, Peoria, IL 61612. You will be notified within approximately 45 days from the receipt of your application as to the status of your request. Incomplete applications will not be processed so please provide ALL documentation.

If you have any questions, please contact our Patient Accounting Department at 309-691-1083.

Thank you

Our Mission *To improve the quality of life of our patients and community by providing quality health care services.*



Financial Assistance Worksheet

Patient Name _____ Date of Birth _____

Guarantor (Responsible Party) Information

Name _____ Date of Birth _____ Social Security # _____

Address _____ Apt # _____ City, State, Zip _____

Home Phone _____ Marital Status _____

Employer Name _____ Wage _____ Hour /Week /Year Full or Part Time

Spouse Name _____ Date of Birth _____ Social Security # _____

Spouse Employer Name _____ Wage _____ Hour /Week /Year Full or Part Time

List name, age, and relationship of all persons living in your household _____

Monthly Income (include information and documentation for spouse if married)

Provide a copy of your _____ Federal Income Tax Return.

Employment \$ _____ Provide copy of (2) most recent pay stubs.

Social Security, Retirement and/or Pension \$ _____ Provide copy of check or annual income statement

Other \$ _____ Provide copy of documentation Child Support/Alimony \$ _____

- If you are unemployed with no income, what is the date you last worked _____? Also, provide a letter as to how you are surviving and meeting your daily expenses. If another party is providing these means for you, please provide a signed document from that party. The document will only be used to process this application for assistance. It does NOT make the other party responsible for your bill.
- If disabled, provide a written statement from your doctor that includes the date you are expected to return to work.

Monthly Expenses

Mortgage or Rent	\$ _____	Auto Payment	\$ _____
Auto/Home Insurance	\$ _____	Health/Life Insurance	\$ _____
Utilities/phone/cable	\$ _____	Credit Card Payments	\$ _____
Child Care / Tuition	\$ _____	Child Support/Alimony	\$ _____
Medical Expenses	\$ _____	Medication	\$ _____

Medicaid Eligibility Screening (check all that apply)

Disabled ___ Blind ___ Pregnant ___ Dependent children under 18 live in your home ___

If any of the above are checked, you must apply for assistance through Medicaid before being considered for Proctor Hospital's Assistance Program. If you are denied by the Medicaid program, provide a copy of your denial with this application.

Attach a letter if you have additional information to provide regarding your financial hardship.

"All the information with this application is true and accurate to the best of my knowledge and I hereby consent to Proctor Hospital verifying any information provided herein with any person or entity."

Signature

Date

Return completed application to Proctor Hospital, PO BOX 3336, Peoria, IL 61612. If you have any questions, call 309-691-1083. Incomplete applications will not be processed.

ATTACH ALL REQUIRED DOCUMENTATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.