Financial Assistance

Assistance

As a Healthcare Institution, we pride ourselves in quality care, and recognize the financial needs within our community. To ensure our patients the best care, Morris Hospital offers assistance to those patients and family members who cannot pay for part or all of the care they receive.

General Information

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing and submitting application to Morris Hospital will help determine if you can receive free or discounted services or other public programs that can help cover your healthcare needs.

Eligibility

Eligibility for financial assistance is determined primarily for the patient based on income and size of family.

***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.**

****Patient may automatically qualify for eligibility criteria established in Section 4500.40 by virtue of the patient's family income; the patient shall not be required to complete the portions off the application.**

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 to help for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for public programs.

Along with application please supply copies of the following documents to verify family income.

- Most recent tax return
- Two most recent pay stubs
- Written income verification from employer if unable to produce pay stubs

Morris Hospital may require additional documentation to apply for Financial Assistance.

Application should be completed and submitted to the hospital in person, by mail, by E-mail or by fax within 90 days following the date of discharge or receipt of outpatient care.

FINANCIAL ASSISTANCE APPLICATION

MORRIS HOSPITAL & HEALTHCARE CENTERS

150 W. High St.
Morris, IL 60450
Ph: 815.942.2932
Fax: 815.941.2476
financialassistance@morrishospital.org

MORRIS HOSPITAL
& HEALTHCARE CENTERS

Morris Hospital Financial Assistance

OFFICE USE ONLY
RECEIVED: POI ☐ TX RTN_____☐ DNF ☐
PRESUMPTIVE: YES ☐ NO ☐
100% ☐ 75% ☐ DENIED ☐ _____
APP EXP. DATE: _____
DATE RECEIVED: _____
RECEIVED BY: _____

Patient Information (PLEASE PRINT ALL INFORMATION)

Patient's Name: _____ Date of Birth: _____
Last *First* *M.I.*

Social Security No: _____

NOTE: If the Patient is a minor please list parent(s) /guardian(s) as applicant and co-applicant

Applicants Name: _____ Date of Birth: _____
Last *First* *M.I.*

Relationship: _____

Address: _____
Street Address *City* *State* *Zip Code*

Phone: _____ Email: _____ Social Security No: _____

Employer: _____ Phone # _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Other__

Were you an Illinois resident when care was rendered by Morris Hospital? YES NO

Were you involved in an alleged accident? YES NO

Are you a victim of an alleged crime? YES NO

Do you have health insurance? YES NO Health Insurance Plan: _____

Number of persons living at the address listed above: _____

Number of persons who are dependents of the patient, & ages: _____

Optional Information

Response/Nonresponse will not have any impact on the outcome of the application

Sex: ☐ Male ☐ Female Preferred Language: ☐ English ☐ Other _____

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Other _____

Financial Information and Income

	Patient Amount/Frequency	Spouse/Partner/Guardian Amount/Frequency
Wages/Unemployment/Work Comp	$ _____ / _____	$ _____ / _____
SS/SSI/SSD	$ _____ / _____	$ _____ / _____
Child Support/Alimony	$ _____ / _____	$ _____ / _____
VA: Pension, Disability, Benefit	$ _____ / _____	$ _____ / _____
Disability	$ _____ / _____	$ _____ / _____
Retirement, Pension	$ _____ / _____	$ _____ / _____
Public Aid/Assistance	$ _____ / _____	$ _____ / _____
Amount in checking/savings	$ _____ / _____	$ _____ / _____
Other Income: _____	$ _____ / _____	$ _____ / _____

Disclaimer and Signature

I certify that my answers are true and complete 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

Signature: _____ Date: _____