

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	\$16,100	\$19,320	\$22,540	\$25,760	\$51,520
2	\$21,775	\$26,130	\$30,485	\$34,840	\$69,680
3	\$27,450	\$32,940	\$38,430	\$43,920	\$87,840
4	\$33,125	\$39,750	\$46,375	\$53,000	\$106,000
5	\$38,800	\$46,560	\$54,320	\$62,080	\$124,160
6	\$44,475	\$53,370	\$62,265	\$71,160	\$142,320
7	\$50,150	\$60,180	\$70,210	\$80,240	\$160,480
8	\$55,825	\$66,990	\$78,155	\$89,320	\$178,640
For each additional person, add	\$5,675	\$6,810	\$7,945	\$9,080	\$18,160
	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 Responsibility (applied before discount)	Primary Care	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	
	Psychiatry	New - \$75; Return - \$45	New - \$75; Return - \$45	New - \$75; Return - \$45	

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