**Kish*Health* System provides** access to high quality health care for all individuals, respecting their dignity, rights, and choices.

As a charitable institution, Kish*Health* System, its hospitals and other affiliates also recognize the importance of providing financial alternatives and charity services for its patients.

**You may qualify for financial assistance**
If you do not have insurance or if you have insurance coverage that does not adequately cover the charges, you may qualify for financial assistance offered by Kish*Health* System to help you meet your financial obligation.

**Are you eligible for Medicaid?**
You may be screened first to determine if you qualify for assistance under the state of Illinois Medicaid program.

- Are you blind?
- Are you disabled?
- Are you over 65?
- Are you the sole supporter of dependents under the age of 18?

If you can answer yes to any of these questions, Patient Financial Services can provide an application for Illinois Medicaid and assist you with the application process if desired.

If you cannot answer yes to the questions above, you may qualify for financial assistance offered by Kish*Health* System.

## *Required Information*

Medical insurance, household income and number of dependents are the main factors considered to qualify for assistance. Financial assistance can be determined by completing a Financial Disclosure Worksheet and providing the following information to Patient Financial Services:

- If you are employed, the last 3 payroll check stubs from each company.
- If self employed, a copy of the most recent profit/loss statement.
- Most recent income tax return signed and dated by individuals who filed OR provide a reason why income taxes were not filed.
- If unemployed and receiving unemployment benefits, a copy of the benefit notification, and the date benefits started.
- A copy of your Social Security checks or bank statement if direct deposited.
- Your workers compensation notification letter, when applicable.
- If you have been unemployed or no income, we require a written statement from the person(s) helping support you.

**For more information**
If you have questions or need assistance, please contact the Patient Accounts Department at 815.756.1521 x153386 or toll free at 800.397.1521 x153386.

For additional information regarding our financial policies, please visit us online at www.kishhospital.org, or www.valleywest.org.

Kish*Health* System

# Financial Assistance

## Kish*Health* System Mission

We are the cornerstone of healthcare for the communities we serve – the first choice for service, comfort and safety. As a community owned health system, the Kish family unselfishly commits to excellence, education and innovation.

Kish*Health* System

# FINANCIAL DISCLOSURE WORKSHEET

Return completed form to: Kish*Health* System
Patient Financial Services
PO Box 846
DeKalb, IL 60115

Date____________________

Patient/Guarantor name: ________________________________ Account # (s): ______________________________

Address:________________________________________________________ Phone #:_______________________
# Street City State Zip

Social Security #:________________________ Date of Birth:__________________ Number in family:____________

Guarantor's Employer:_____________________________________________________ Years there: _______________

Approx. Income: $________________________ (weekly, bi-weekly, monthly) (gross, net)

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Spouse's Name:_________________________________________________ Spouse's S.S.#:______________________

Spouse's Employer:______________________________________________ Years there: _________________________

Approx. Income: $________________________ (weekly, bi-weekly, monthly) (gross, net)

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Other Monthly Income: $ _______________________ $ _______________________ $ _______________________

Describe Other Income_____________________________________________________________________________

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Please list name, age and relationship of all persons living with you. (Exclude yourself)

Name Age Relationship Name Age Relationship

1.______________________________________________ 3.______________________________________________

2.______________________________________________ 4.______________________________________________

| | Monthly Payment | Balance | Medical Bills |
|---|---|---|---|
| Rent/Mortgage | ____________ | ____________ | ______________________ |
| Car/Truck Loan(s) | ____________ | ____________ | ______________________ |
| Other Loan(s) | ____________ | ____________ | ______________________ |
| Auto Insurance | ____________ | ____________ | ______________________ |
| Medical Insurance | ____________ | ____________ | ______________________ |
| Food/Groceries | ____________ | ____________ | |
| Utilities | ____________ | ____________ | |
| Telephone | ____________ | ____________ | |
| Credit Card(s) | ____________ | ____________ | |
| Other:________ | ____________ | ____________ | |

I have carefully read and submitted the foregoing information provided on this worksheet to Kish*Health* System.
The information is presented as a true and accurate statement of my financial condition on the date indicated.

I authorize Kish*Health* System to make whatever credit inquires it deems necessary in connection with this worksheet. I also authorize and instruct any person or consumer reporting agency to furnish to the hospital any information that it may have or obtain in response to such credit inquiries. I understand and agree to cooperate with case management for assistance in determining medical necessity for the care that I am receiving.

__________________________________________________________ Date: ______________________________

Patient/Guarantor Signature