

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

As a charitable institution, KishHealth 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 KishHealth 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 KishHealth 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.
- » 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 815.748.8983 or toll free at 800.397.1521 x8983.

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

**KishHealth System
Financial Assistance**



KishHealth 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.

FINANCIAL DISCLOSURE WORKSHEET

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

Date _____

Patient/Guarantor name: _____ Account # (s): _____

Address: _____ # Street _____ City _____ State _____ Zip _____ Phone #: _____

Social Security #: _____ Date of Birth: _____ Number in family: _____

Guarantor's Employer: _____ Years there: _____

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

Spouse's Name: _____ Spouse's S.S.#: _____

Spouse's Employer: _____ Years there: _____

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

Other Monthly Income: \$ _____ \$ _____ \$ _____

Describe Other Income _____

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 KishHealth System. The information is presented as a true and accurate statement of my financial condition on the date indicated.

I authorize KishHealth 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.

_____ Date: _____

Patient/Guarantor Signature