Mokena Fire Protection District

REQUEST FOR FINANCIAL ASSISTANCE

Date: _____

Patient Name: _____

Date of service: _____

You may be able to receive free or discounted health care services. Completing this application will help the Mokena Fire Protection District determine if you can receive free or discounted services that can help pay for your Emergency Medical Services care and transportation. Please submit this application to the Mokena Fire Protection District.

If you are uninsured, a social security number is not required to qualify for free or discounted health care services. However, a social security number is required for some public programs, including Medicaid. Providing a social security number is not required but will help the Mokena Fire Protection District determine whether you qualify for any public programs.

Please complete this form and submit it to the Mokena Fire Protection District in person, by mail, by electronic mail, or by fax to apply for free or discounted health care services within 90 days following the date of the health care.

The 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.

Information collected on this form, including (but not limited to) name, phone number, email address, postal address, financial and employment information, will only be used by the Mokena Fire Protection District for the purpose of determining financial assistance eligibility and processing payment, and will be treated in confidence and not be disclosed to any other party except where permitted in the "Notice of Privacy Practices", accessible at www.mokenafire.org. This form will be destroyed as soon as practical once your eligibility for financial assistance has been determined.

DEMOGRAPHIC INFORMATION

Patient name (or applicant if patient is a minor):_____

Address:_____

Home/Cell number:_____Date of birth:_____

Social Security #_____Email address:_____

Spouse/Partner:_____

Address:_____

Social Security #_____Date of birth:_____

Family size/dependents:

Name of dependent(s)	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the patient is a minor, is a former spouse/partner financially responsible for patient's medical care due to a dissolution/separation agreement? Yes No

Is the patient an Illinois resident? Yes No

Is the patient a resident of the Mokena Fire Protection District? Yes No

Was the patient a victim of a crime? Yes No

Was this healthcare due to an alleged accident? Yes No

EMPLOYMENT / INCOME

Patient/applicant employer Name:_____Phone:_____

Employer Address:_____

Spouse/partner employer name:_____Phone:_____

Address:_____

Do you receive any of the following:

WIC	Yes	No
SNAP	Yes	No
Free lunch/breakfast program	Yes	No
LIHEAP	Yes	No

MONTHLY INCOME FROM THE FOLLOWING:	PATIENT/APPLICANT	SPOUSE/PARTNER
Gross monthly income	$_____	$_____
Self employment	$_____	$_____
Unemployment	$_____	$_____
Social security/disability	$_____	$_____
Retirement/pension	$_____	$_____
Workers compensation	$_____	$_____
Temp assistance for needy families	$_____	$_____
Child support/alimony	$_____	$_____
Other	$_____	$_____

****This application will not be approved without proof of income and supporting documentation.** Please attach copies of all financial information that applies. Please return within 60 days of service provided.

Current check stubs; tax return and W2 forms for previous year; letter of support, room and board; unemployment letter; summary of LIND benefits from DHS; Social Security earned statement; court orders; assistance from organizations (ie township, church, catholic charities); if self employed, record of current earnings and previous year taxes.

INSURANCE INFORMATION

Do you have medical insurance? Yes No

Patient/applicant insurance company:_____

Address:_____

Group #_____Policy #_____Phone:_____

Spouse/partner insurance company:_____

Address:_____

Group #_____Policy #_____Phone_____

ASSET INFORMATION

List the value of each asset:

Checking	$_____	Mutual Funds	$_____
Savings	$_____	Auto / Other Vehicles	$_____
Stocks	$_____	Real Property	$_____
Certificates of Deposit	$_____	Health Savings/ Flex Spending Account	$_____

MONTHLY EXPENSES

List your total monthly expenses for each:

Housing	$_____	Child Care	$_____
Utilities	$_____	Loans	$_____
Food	$_____	Medical Expenses	$_____
Transportation	$_____	Other Expenses	$_____

Based upon the information received with this application, if the patient is determined to be presumptive eligible, no additional information is required.

I certify that the information in this application is true and correct 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 bill. I understand that the information provided may be verified by the Mokena Fire Protection District, and I authorize the Mokena Fire Protection District 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 the application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of this healthcare bill.

Patient/applicant_____Date_____

Spouse/partner_____Date_____

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