Wabash General Hospital
People you know, helping people you love

1418 College Drive
Mount Carmel, IL 62863
WabashGeneral.com

Wabash General Hospital Financial Assistance Application Form

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Wabash General Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

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

Please complete this form and submit in one of the following ways:

- **-To the Business Office in person at 1001 N Market St Mt Carmel, IL**
- **-By mail to 1418 College Drive Mt Carmel, IL 62863 Attention to Financial Assistance**
- **-By electronic mail to BusinessOffice@wabashgeneral.com**
- **-By fax at (618) 263-6467**

To apply for free or discounted care applications should be completed within 60 days following the date of discharge or receipt of Out-patient care. If you have any questions please contact the Business Office at (618) 263-6412.

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 Information:

Patient Name**:** _____

Patient Date of Birth**:** _____

Social Security Number: __ __ __/__ __ /__ __ __ __

Patient Address**:** _____

Patient Telephone Number**:** _____

Guarantor Information: (In the case the patient is a minor child.)

Guarantor Name: _____

Guarantor Address: _____

Guarantor Telephone Number: _____

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Family/Household Information:

1. Number of persons in the patient's family/household. _____
2. Number of persons who are dependents of the patient. _____
3. Ages of dependents. _____ , _____, _____, _____, _____, _____,_____

Patient's Family Income and Employment Information:
(If the patient is a minor, complete Guarantor and Spouse columns if applicable. If the patient is over the age of 18, complete the Patient and Spouse columns if applicable.**)**

	Patient	**Guarantor**	**Spouse (Partner)**
1. Check the column of who is currently employed.	_____	_____	_____
2. Name of Employer?	_____	_____	_____
List Monthly Income Amounts			
3. Wages (Gross Monthly)	_____	_____	_____
4. Unemployment Compensation	_____	_____	_____
5. Social Security	_____	_____	_____
6. Disability Income	_____	_____	_____
7. Worker's Compensation	_____	_____	_____
8. Temporary Assistance	_____	_____	_____
9. Retirement (Pension)	_____	_____	_____
10. Child Support or Alimony	_____	_____	_____
11. Other Income	_____	_____	_____
Totals	_____	_____	_____

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Include Proof of Income with Application:

The following are examples of acceptable proof of income used for the determination of financial assistance. It is at the discretion of Wabash General Hospital to determine acceptable proof of income.

If you file income taxes please provide the following with the completed application:

- **Current Federal Income Tax Return (Preferred proof of income)**
- **Current Bank Statements (Past 3 months)**
- **Current Pay Stubs (Past 3 months)**

If you do not file income taxes please provide the following :

- Current Pay Stubs (Past 3 months)
- Unemployment Compensation Letter/Notice
- Current Bank Statements (Past 3 months)
- Recent LES for Military Personnel
- Social Security Administration Benefit Letter

NOTE: Applications will not be processed without supporting documentation.

Insurance Benefit Information:

1. Do you have health insurance coverage?	Y or N
If yes, do you have:	
Medicare?	Y or N
Medicare Part D?	Y or N
Medicare Supplement?	Y or N
Medicaid?	Y or N
Veterans' Benefits?	Y or N
2. Have you enrolled in the state Medicaid plan or Market Place?	Y or N

Certification Statement:
I certify that the information in this application is true and correct to the best of my knowledge. 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 for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Patient or Applicant: _____
Date _____

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Effective
1/1/2025

Uninsured Discount

Family Size	< = 200% 100% Discount	< = 300% Based on gross income Does not qualify
1	0 – 31,300	46,950.00
2	0 – 42,300	63,450.00
3	0 – 53,300	79,950.00
4	0 – 64,300	96,450.00
5	0 – 75,300	112,950.00
6	0 - 86,300	129,450.00
7	0 – 97,300	145,950.00
8	0 – 108,300	162,450.00

For each additional
Person, Add $5,380

updated 1/22/25