



# HEARTLAND COMMUNITY HEALTH CLINIC

## ... A Community of Caring

1701 W. Garden Street • Peoria, Illinois 61605-3531  
 Phone (309) 680-7600 • Fax (309) 680-7686

Dear Patient:

Heartland Community Health Clinic offers financial assistance to patients who do not have any other form of health insurance benefits. Depending on verification of your income and household size, you may qualify for a discount on your office visit charges at HCHC.

An application for financial assistance is attached. The following documentation of your income will be needed in order to process your application for eligibility.

- Completed and signed financial assistance application
- Income Verification: **(Provide all that apply to your household.)**
  - Last 4 pay stubs (or representing a month) for you and your spouse
  - Proof of Social Security benefits, if applicable
  - Proof of Pension Income, if applicable
  - If unemployed, proof of unemployment benefits
- A complete copy of your most recent income tax return, with W-2's

Your application cannot be processed without **ALL** necessary documentation.

**All patients will be required to pay their portion of the bill at the time of registration. A minimum payment of \$20 will be requested towards your co-pay, which will be determined once your application has been processed. You will be responsible for any remaining balance if your co-pay is greater than \$20.**

**Heartland Clinic has no lab or x-ray services.** Any labs or x-rays provided on site are under contract with another organization. (For instance, at Garden Street the lab and x-ray services are performed by OSF. You will be billed in full by OSF.) **To obtain financial assistance discount on labs or x-ray services, you must contact the organization providing the services.**

If you have any questions regarding your application or this process, please contact Billing at (309) 680-7621 at Heartland Community Health Clinic.

We look forward to assisting you.

Sincerely,

Nancy Neel  
 Chief Financial Officer

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## PATIENT FINANCIAL ASSISTANCE APPLICATION

Aplicación para Asistencia Financiera para el Paciente

**Name:** \_\_\_\_\_  
 Nombre Last / Apellido First / Primer nombre Middle Initial / Inicial de Segundo nombre

**Address:** \_\_\_\_\_  
 Dirección Include Complete Street Address with Apartment Numbers and/or P.O. Box Numbers  
 Incluya la dirección completa, la calle, el numero de casa y numero de apartamento y/o el numero de caja postal

City / Ciudad County / Condado State / Estado Zip Code / Código Postal

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
 Teléfono Particular Teléfono Celular  
**Date of Birth:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_  
 Fecha de Nacimiento # de Seguro Social

**Marital Status:** Single / Soltero(a) Married / Casado(a) Separated / Separado(a) Divorced / Divorciado(a) Widowed / Viudo(a)  
 Estado Civil

### PATIENT / PACIENTE

### SPOUSE / CONYUGE

	Yes / Si	No	Yes / Si	No
<b>Are you employed:</b> Esta usted trabajando?				
<b>Name of Employer:</b> Nombre de la Empresa				
<b>Address:</b> Dirección				
<b>Employer Contact Person:</b> Contacto en la Empresa				
<b>How many hours/week are worked:</b> Cuántas horas trabaja a la semana?				
<b>What is hourly rate of pay:</b> Cuanto le pagan por hora?				
<b>How often paid:</b> Cada cuando le pagan?				
<b>Employer phone #</b> Teléfono de la Empresa				

**Did you file Income Taxes Last Year?** (If yes, please attach copy, including W-2's) Yes / Si No  
 Realizo su declaración de impuestos el año pasado? (Si respondió SI, por favor agregue una copia)

**Do you or your spouse receive unemployment benefits?** Recibe usted o su cónyuge beneficios de desempleo? Yes / Si No

**If yes, how much per month?** Si respondió SI, cuanto recibe al mes? \_\_\_\_\_

**Do you or your spouse receive Social Security retirement?** Recibe usted o su cónyuge retiro por parte del Seguro Social? Yes / Si No

**If yes, how much per month?** Si respondió SI, cuanto recibe al mes? \_\_\_\_\_

**Do you or your spouse receive Social Security disability?** Recibe usted o su cónyuge discapacidad por parte del Seguro Social? Yes / Si No

**If yes, how much per month?** Si respondió SI, cuanto recibe al mes? \_\_\_\_\_

**Do you or your spouse receive a pension?** Recibe usted o su cónyuge pensión? Yes / Si No

**If yes, how much per month?** Si respondió SI, cuanto recibe al mes? \_\_\_\_\_

**Do you receive Food Stamps?** Recibe usted Estampillas de comida? Yes / Si No

**If yes, how much do you receive per month?** Si respondió SI, cuanto recibe al mes? \_\_\_\_\_

**If unemployed, and you do not receive any of the above mentioned income, how do you meet your day to day needs** (Si esta usted desempleado y no recibe ninguno de los beneficios anteriormente mencionados, como satisface usted sus necesidades del día a día): \_\_\_\_\_

**Please complete this part of the application before returning it. If we need any more information from you, we will notify you.**

Por favor complete esta parte de la aplicación antes de regresarla. Si nosotros necesitamos más información, nosotros le notificaremos

**You may be eligible for the Medical Card.** (Usted puede ser elegible para obtener la Tarjeta Medica)

- |   |          |    |
|---|----------|----|
| 1. Are you 65 or older? Es usted 65 años de edad o mayor?   | Yes / Si | No |
| 2. Are you receiving Social Security Disability?<br>Esta usted recibiendo Discapacidad por parte del Seguro Social?     | Yes / Si | No |
| 3. Are you legally blind? Esta usted legalmente ciego?  | Yes / Si | No |
| 4. Are you pregnant? Esta usted embarazada?   | Yes / Si | No |
| 5. Do you have dependent children under the age of 18 in your home?<br>Tiene usted niños menores de 18 años en la casa? | Yes / Si | No |

**\*If you answered YES to any of these questions, you must first contact your county's Department of Health & Family Services (formerly Public Aid) office for a medical card. If denied, your financial assistance application will then be considered.**

\*Si usted respondió SI a cualquiera de estas preguntas, usted debe contactar la oficina del Departamento de Salud y Servicios a la Familia (anteriormente Public Aid) para solicitar la tarjeta medica. Si no lo aceptan, su aplicación de ayuda financiera será considerada.

**Total number of dependents living with you:** Numero total de dependientes que viven con usted

**Under 18** (Menores de 18) \_\_\_\_\_

**Over 18** (Mayores de 18) \_\_\_\_\_

**Family Size** (Tamaño de su familia) \_\_\_\_\_

<b>Dependant Name</b> Nombre del dependiente	<b>Age</b> Edad	<b>Relationship to Patient</b> Relación con el paciente

**My signature below represents that the above information is true and correct. I understand that any falsification of this information will result in termination of financial assistance.**

Mi firma aquí indica que la información proporcionada es verdadera y correcta. Entiendo que cualquier información falsa resultara en la terminación de la ayuda financiera

\_\_\_\_\_  
Signature / Patient or Guardian  
Firma / Paciente o Tutor

\_\_\_\_\_  
Signature / Screener  
Firma

\_\_\_\_\_  
Date Signed  
Fecha

\_\_\_\_\_  
Date Signed  
Fecha

# Heartland Community Health Clinic

1701 W. Garden Street Peoria, IL 61605

Ph: (309) 680-7600

## Patient Financial Assistance Application

Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
(Include Complete Street Address with Apartment Numbers and/or P.O. Box Numbers)

\_\_\_\_\_  
City County State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Are YOU employed: Yes No  
Name of Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer Contact Person: \_\_\_\_\_  
How many hours/week are worked: \_\_\_\_\_  
What is hourly rate of pay: \_\_\_\_\_  
How often paid: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Is SPOUSE employed: Yes No  
Name of Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer Contact Person: \_\_\_\_\_  
How many hours/week are worked: \_\_\_\_\_  
What is hourly rate of pay: \_\_\_\_\_  
How often paid: \_\_\_\_\_  
Employer Phone #: \_\_\_\_\_

Did you file Income Taxes Last Year: Yes No (If yes, please attach copy, including W-2's.)

Do you or spouse receive unemployment benefits: Yes No  
If yes, how much per month: \_\_\_\_\_

Do you or spouse receive Social Security retirement? Yes No  
If yes, how much per month: \_\_\_\_\_

Do you or spouse receive Social Security disability? Yes No  
If yes, how much per month: \_\_\_\_\_

Do you or spouse receive a pension: Yes No  
If yes, how much per month: \_\_\_\_\_

Do you receive Food Stamps: Yes No If yes, how much do you receive per month: \_\_\_\_\_

If unemployed, and you do not receive any of the above mentioned income, how do you meet your day to day needs: \_\_\_\_\_

**Please complete this part of the application before returning it. If we need any more information from you, we will notify you.**

**You may be eligible for a Medical Card.**

- |   |     |    |
|---|-----|----|
| 1. Are you 65 or older:   | Yes | No |
| 2. Are you receiving Social Security Disability:                    | Yes | No |
| 3. Are you legally blind:   | Yes | No |
| 4. Are you pregnant:  | Yes | No |
| 5. Do you have dependent children under the age of 18 in your home: | Yes | No |

**\*If you answered YES to any of these questions, you must first contact your county's Department of Health & Family Services (formerly Public Aid) office to apply for a medical card. If denied, your financial assistance application will then be considered.**

**Total number of dependents living with you: Under 18: \_\_\_\_\_ Over 18: \_\_\_\_\_**

**Family Size: \_\_\_\_\_**

**Dependant Name, Age, and Relationship to Patient:**

_____	_____
_____	_____

**My signature below represents that the above information is true and correct. I understand that any falsification of this information will result in termination of financial assistance.**

\_\_\_\_\_  
Signature / Patient or Guardian

\_\_\_\_\_  
Signature / Screener

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Signed