Hospital Financial Assistance Application

Please fill out the application online at https://touchette.myfa.app or scan the QR code

For paper application, please continue.

Patient First & Last Name & DOB: _____ Social Security # (SS#): _____

Guarantor First & Last Name: _____ SS#: _____
(Guarantor is the person responsible for the debt) (No Social Security # will not impact financial assistance but will assist in public program determination)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Guarantor Email Address: _____

STOP! Is the patient or guarantor currently receiving assistance from any of the following. If yes, bring a copy of the assistance information in the patient's or guarantor's name to Touchette Regional Hospital Registration with completed application or you can send it online https://touchette.myfa.app/ by taking a picture of the document with your phone.

- Temporary Assistance for Needy Families (TANF)
- WIC
- Illinois Free Lunch & Breakfast Program
- Supplemental Nutrition Assistance Program (SNAP)
- Illinois Housing Dev Authority's Rental Housing Support
- Bankruptcy within the past 6 months
- Low Income Home Energy Program (LIHEAP)

Family Size/Dependents Section:

Number of people living in your household _____

Dependents (living in your home) if more space is needed, please add them to the back of the sheet

Name	Date of Birth or Age	Relationship to Guarantor

Income Section: All income for household

Employer Name and City: _____

Spouse Employer Name and City: _____

If the guarantor is not employed, how are you meeting your living expenses?

_____

_____

List all sources of income including, but not limited to, wages, self-employment, unemployment, disability, social security, pension, child support, pension, and/or any other income sources.

Source of Payment	Amount	How Often (per week, 2 weeks, monthly)

Proof of income is required. Please submit the most recent tax return or last pay stub(s).

Health Insurance Section: Do you have health insurance? Yes _____ No _____

Name of Insurance _____ Insurance Phone _____

Subscriber _____ Policy # _____ Group # _____

Certification Section:

I certify that the information in this application is true and complete. I will apply for any state, federal or local assistance to help pay for these medical expenses. I understand that the information provided may be verified by my medical providers and I authorize them to contact any necessary third parties to verify the accuracy of the information provided in this application. I understand that if the above information is untrue, any financial assistance granted to me may be reversed and I will be responsible for the payment of these medical expenses.

Patient/Guarantor Signature**:** _____

Date: _____

IMPORTANT: YOU MAY QUALIFY FOR FREE OR DISCOUNTED CARE

Completing this application will help Touchette Regional Hospital determine if you can receive care or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the Touchette Regional Hospital Registration or Customer Service Department within 60 days of receiving the first billing statement.

You can email, mail or fax your application and all supporting documentation to:
Touchette Regional Hospital
Attention: Angie Merten
5900 Bond Ave
Cahokia Heights, Il 62207

Fax: (618) 332-5242; **Email:** Financial_Assistance@Touchette.org **Online**: https://touchette.myfa.app/

**** NOTE**** **- Application and supporting documentation must be received within 90 days of the date of service.**