Kirby Medical Center
1000 Medical Center Drive
Monticello, IL 61856
Phone: 217-762-1540
Fax: 217-762-1542

APPLICATION FOR FINANCIAL ASSISTANCE

For Kirby Medical Center to process your application, all sections must be completed. Along with your application, required documents may include:

- Proof of income for all income sources (previous year's tax return, last two months' pay stubs, social security benefit letters, etc.)
- Bank statements (last two months)
- State Letter (if applicable)

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information.

Applicant Name: _____ Social Security #: (optional) _____
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State:____ Zip Code:_____

Phone Number: _____ Email: _____

(The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application.)

Race: _____ Ethnicity: _____

Sex: _____ Preferred Language: _____

Please mark all that apply. If you have checked one or more boxes, you only need to submit your approval letter from the appropriate state department. No further financial documentation is needed.

□ Illinois Medicaid (Title XIX) □ SNAP or WIC □ Low Income Home Energy Assistance Program (LIHEAP) □ Illinois Free Lunch and Breakfast Program □ Homeless

SECTION TWO: HOUSEHOLD MEMBERS and INCOME INFORMATION

Please provide the following information for all immediate family members who live in your home. For application purposes, family is defined as the applicant, the applicant's spouse, and all of the applicant's children under 18 (natural or adoptive) who live in the applicant's home.

Name	Date of Birth	Relationship to Applicant	Total Gross Monthly Income (All Sources)
(Applicant)		self	

If there is no income, please explain how applicant is supporting themself: _____

_____

_____

Was your service related to a worker's compensation claim or motor vehicle accident? Yes / No

SECTION THREE: ASSETS INFORMATION

Please provide banking information for members of the household.

Asset Type	Current Balance – Applicant	Current Balance – Spouse/Other
Bank Account - Savings		
Bank Account - Checking		

SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Insurance Company Name: _____ Insurance Phone Number: _____
Group Number:_____ Member ID Number: _____

I certify that the above information is true and accurate to the best of my knowledge. I will apply and take any reasonable action needed to get assistance (Medicaid, Medicare, Insurance, etc.) to pay my hospital charges. Financial assistance is a source of last resort. Any other liability or possible payer will be exhausted prior to awarding assistance. I understand that this application is made so that the hospital can see if I am eligible for financial assistance based upon defined criteria.

Signature of Applicant:_____ Date:_____

Complaints or concerns with the patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General – (877) 305-5145.
https://www.illinoisattorneygeneral.gov/File-A-Complaint/index