Services provided at the following locations are eligible for financial assistance. To pick up an application, visit one of these locations, visit blessinghealth.org/billing or scan this QR code.

Illinois

Blessing Hospital
11th & Broadway | Quincy, IL

Illini Community Hospital
640 West Washington Street | Pittsfield, IL

Blessing Health Center
927 Broadway
Quincy, IL

Blessing Health Center
4800 Maine
Quincy, IL

East Adams Rural Health Clinic
102 Prairie Mills Road | Golden, IL

Hamilton-Warsaw Clinic
1102 North County Road 700 | Warsaw, IL

Illini Rural Health Clinic
640 West Washington | Pittsfield, IL

Mt. Sterling Clinic
521 East Main Street | Mt. Sterling, IL

Missouri

Blessing Health Hannibal
100 Medical Drive | Hannibal, MO

Blessing Health Monroe City
400 North Main | Monroe City, MO

Blessing Health Palmyra
6996 County Road 326 | Palmyra, MO

Kahoka Medical Clinic
103 East Commercial Street | Kahoka, MO

blessinghealth.org

BLESSING Health System

Blessing Health System (BHS) believes that every person who needs medically necessary care should receive medical care, even if they don't have the financial resources to pay the bill.

You may be able to receive free or discounted care at Blessing Health System providers. By completing this application, BHS will determine if you can receive free or discounted services or other public programs, including Medicaid.

The following rules apply to any financial assistance application made to BHS:

- You must have needed non-elective care (care needed due to an illness or injury)
- You don't have health insurance
- You don't have enough health insurance and cannot pay for the care you received.
- The amount of income you have must meet rules set by the federal government.

Please complete this application and submit with the requested documentation to the hospital in person, by mail, or by fax to apply for free or discounted 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. That patient also understands that all correspondence regarding any person named on this application will be mailed to the applicant at the address listed on the application.

People come to BHS for great medical care. We deliver that care to everyone, no matter their religion, race or income.

Maximum Collectable Amount

Patients with eligible expenses from Blessing or Illini Hospital that exceed 20% of your family income are eligible for a discount under our Uninsured Patient Discount Policy. You may include health care expenses received in the last 12 months toward your Maximum Collectible Amount.

Questions or Concerns

If you have questions or concerns, you may contact Blessing Health System Patient Financial Services by calling (855) 354-5896 or (217) 277-3512.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at:

illinoisattorneygeneral.gov/consumers/healthcare

1-877-305-5145 (TTY 1-800-964-3013)

Blessing Financial Assistance Application

Please complete your signed Financial Assistance Program Application and submit to Patient Financial Services at one of the locations below:

Blessing Health Center 927 Broadway
Suite 106
Quincy, IL 62301

Blessing Health Hannibal
100 Medical Drive
Hannibal, MO 63401

Applications may also be faxed to **217.214.5846**.

BHS Financial Assistance Program Application (please print)

Name: _____ Phone Number: _____

Address: _____ City/State/ZIP: _____

Date of Birth: _____

Employer(s): _____ Hire Date(s): _____

OPTIONAL DEMOGRAPHIC INFORMATION *(Any response or nonresponse will not have any impact on the outcome of the application.)*

Race: _____ Ethnicity: _____ Sex: _____ Preferred Language: _____

Spouse's Information *(If Applicable)*

Name (First, Middle, Last): _____

Date of Birth: _____

Employer(s): _____ Hire Date(s): _____

OPTIONAL DEMOGRAPHIC INFORMATION *(Any response or nonresponse will not have any impact on the outcome of the application.)*

Race: _____ Ethnicity: _____ Sex: _____ Preferred Language: _____

List Dependents *(If different from tax return, please explain)*

OPTIONAL DEMOGRAPHIC INFORMATION *(Any response or nonresponse will not have any impact on the outcome of the application.)*

Name	Date of Birth	Relationship	Race	Ethnicity	Sex	Preferred Language

If you are employed, please provide 3 most recent and consecutive paystubs.
If you are unemployed with no source of income, please explain below how you pay for your basic living needs.
Explain: _____

Are you self-employed? Yes _____ No _____
If yes, were you self-employed for all of last year? If not please contact our office for additional documentation.

Do you and/or spouse currently receive other monthly income? Yes _____ No _____
(examples: Social Security, pension, rental income, child support, unemployment, etc.)
If yes, please provide official documentation, from the source, that states your current gross income.

Did you file your most recent income tax return? Yes_____ No_____
If yes, please provide a copy of the Federal Income Tax Return including all Schedules, W-2 Statements, and 1099 Forms.
If you do not have to file taxes, please explain below.
Explain: _____

The above documentation must be attached to the fully completed and signed BHS Financial Assistance Application.

I certify that the information in this application is true and correct to the best of my knowledge. I understand my signature authorizes 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/clinic bill.

Signature: _____ Date: _____