CHRISTOPHER RURAL HEALTH
PLANNING CORPORATION

Kimberly Mitroka, President/CEO

833-209-0498

www.crhpc.org

4241 STATE HWY 14 W.
PO BOX 155
CHRISTOPHER, IL 62822

Financial Assistance Programs

Dear Patient,

Thank you for choosing our facilities for your healthcare needs. Our facility offers a Sliding Fee Program to all patients based on household size and income. This program can offer financial assistance for medical, dental, and pharmaceutical services.

How to apply:

1. **Complete the Sliding Fee Application,** you must include all household members in your application

2. **Provide proof of household income.** Applicants must provide one of the following for each member of your household receiving income. Acceptable documentation of income may include the following:

*Statement of wages, most recent 30 days
*Form 4506-T
*Child Support/Alimony
*Self-Employed-30 Day Gross Income
*W2 Form from employer
*Letter from employer
*Assistance Certification
*SS Verification Letter
*Most Recent Federal Tax Return
*Unemployment Benefits
*Recent SS/Disability Award Letter

INDIVIDUALS WITH NO INCOME

For individuals receiving assistance: Please have the person who is providing assistance complete the Assistance Certification Form. *Please remember, the assistance does not always have to be in the form of cash. It can refer to personal products, transportation provided, shelter, food, etc.*

For assistance or questions regarding the application process, please contact any of our locations at the number listed below.

Albion Community Health Center	618-724-6683
Benton Rea Clinic	618-724-1753
Carrier Mills Community Health Center	618-724-1719
Christopher Rea Clinic	618-724-1753
CRHPC-Carmi Health Center	618-724-6683
Clay Medical Center	618-724-1750
DuQuoin Rea Clinic	618-724-1706
Eldorado Rural Health Clinic	618-724-1719
Fairfield Community Health Center	618-724-6606
Johnston City Community Health Center	618-724-1727
Mt. Vernon Community Health Center	618-724-6586
Sesser Community Health Center	618-724-6586
Shawneetown Healthcare Clinic	618-724-1719

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PLEASE FILL OUT TO APPLY FOR OUR SLIDING FEE DISCOUNT PROGRAM

HOUSEHOLD INCOME DOCUMENATION WILL BE REQUIRED TO QUALIFY

Name:			
Address:			
City, State, Zip Code:			
Social Security #:		**Birthdate:**	
Telephone #:		**Insurance:**	

Family/Household Information:

Name	Birthdate	Applying for Benefits	Insurance
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Household Income Information: **Did anyone file taxes for the previous year?** ☐ Yes ☐ No

Name of household member receiving income	Source of Income	Annual Gross Income (Before Deductions)

☐ I authorize Christopher Rural Health Planning Corporation to obtain necessary information from my healthcare provider, or others as needed to complete applications for medication assistance and to share information with pharmaceutical companies as required

☐ I give permission to Christopher Rural Health Planning Corporation to sign patient assistance applications for me to order my medication. This consent is valid as long as I am a patient of Christopher Rural Health Planning Corporation, or until I revoke my permission in writing.

☐ I do not have pharmaceutical coverage, including but not limited to Medicare Part D.

I hereby certify by signing below that the above information I have provided on this form to be true, accurate and complete. I promise to notify CRHPC of any changes in my income, mailing address, telephone number or insurance in a timely manner. I understand that CRHPC will review my income status at a minimum annually, at which time I will be asked to supply documentation supporting my current situation. If I refuse such a review, CRHPC will no longer apply discounts to mine or my family's accounts. I also understand that any applicable copay amounts are due at the time of service.

Signature:_____ Date:_____

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ASSISTANCE CERTIFICATION

This statement is to be completed and signed by the individual who is providing assistance to the following **Christopher Rural Health Planning Corporation** patient(s).

Name/DOB of patient(s) receiving assistance:

_____

_____

I am currently providing assistance for the above patient(s). This assistance may be in the form of cash, personal items, transportation, etc.

Estimated dollar amount provided for the past thirty (30) days: $_____

_____ I have provided shelter for the above patient(s) for the past thirty (30) days.

Assistance Provider Information:

Name:_____

Address:_____

Phone:_____

_____ _____

Signature of the Assistance Provider Date