



www.crhpc.org



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

Kimberly Mitroka, President/CEO

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 <u>one</u> of the following for <u>each</u> member of your household receiving income. Acceptable documentation of income may include the following:
 - *Statement of wages, most recent 30 days
- *W2 Form from employer
- *Most Recent Federal Tax Return

*Form 4506-T

- *Letter from employer
- *Unemployment Benefits

*Child Support/Alimony

- *Assistance Certification
- *Recent SS/Disability Award Letter

- *Self-Employed-30 Day Gross Income
- *SS Verification 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



CHRISTOPHER RURAL HEALTH PLANNING CORPORATION



833-209-0498



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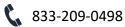
CHRISTOPHER, IL 62822

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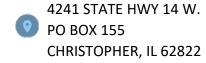
PLEASE FILL OUT	TO APPLY FOR	OUR SLIDING F	EE DISCOUNT	PROGRAM
HOUSEHOLD INC	OME DOCUME	NATION WILL E	BE REQUIRED T	O QUALIFY

	HOUSEHOLD INCOME	DOCUMENATION WILL BE	REQUIRED I	U QUALIFY
lame:				
Address:				
City, State, Zip Code:				
Social Security #:			Birthdate:	
Telephone #:			Insurance:	
amily/Household Information:	•			
Name	Birthdate	Applying for Benefits	6	Insurance
		Yes No		
	o complete applications fo	g Corporation to obtain nece or medication assistance and		on from my healthcare provider, or nation with pharmaceutical
	onsent is valid as long as			ance applications for me to order m lanning Corporation, or until I revok
I do not have phar	maceutical coverage, inclu	ding but not limited to Medi	icare Part D.	
of any changes in my income, ma tatus at a minimum annually, at	ailing address, telephone num which time I will be asked to	nber or insurance in a timely ma supply documentation support	nner. I understa ing my current si	and complete. I promise to notify CRHP and that CRHPC will review my income ituation. If I refuse such a review, CRHPC and 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: