REQUEST FOR ASSISTANCE ON MEDICAL BILL

Date: Patient Name:

Account #: Date of Service:

You may be able to receive free or discounted care. Completing this application will help Silver Cross Hospital determine if you can receive free or discounted services or eligible for other public programs that can help pay for your healthcare. Please submit this application to the Hospital.

Any free or discounted amount determined by this application will only cover amounts owed to Silver Cross Hospital. You may receive separate bills from Providers who may treat you. These Providers may have their own financial assistance policy or practice. Patients are encouraged to ask the provider if they offer financial assistance.

If you are uninsured, a social security number is not required to qualify for free or discounted care. However, a social security number is required for some public programs, including Medicaid. Providing a social security number is not required but will help the Hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the Hospital in person, by mail, by electronic mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient 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.

DEMOGRAPHIC INFORMATION:

Patient, (or applicant if Patient is a minor): _____

Address: _____

Home/Cell Number: _____ Date Of Birth: _____

Social Security #: _____ Email Address: _____

OPTIONAL - RESPONSE DOES NOT IMPACT THE OUTCOME OF THE APPLICATION

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

Spouse/Partner: _____

Address: _____

Social Security #: _____ Date of Birth: _____

FAMILY SIZE/DEPENDENTS:

NAME OF DEPENDENTS	**AGE**	**RELATIONSHIP**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the patient an Illinois Resident? YES NO
Was the patient a victim of a crime? YES NO
Was this visit due to an alleged accident? YES NO

If the patient is a minor, is a former spouse/partner financially responsible for the patient's medical care due to a dissolution/separation agreement? YES NO

EMPLOYMENT/INCOME SECTION:

Patient/Applicant Employer Name: _____ Phone: _____
Address: _____

Spouse/Partner Employer Name: _____ Phone: _____
Address: _____

MONTHLY INCOME FROM THE FOLLOWING:	**PATIENT/APPLICANT**	**SPOUSE/PARTNER**
Gross Monthly Income	$_____	$_____
Self-Employment	$_____	$_____
Unemployment	$_____	$_____
Social Security/Disability	$_____	$_____
Retirement/Pension	$_____	$_____
Workman's Compensation	$_____	$_____
Temp Assistance for Needy Families	$_____	$_____
Child Support/Alimony	$_____	$_____
Other	$_____	$_____

DO YOU RECEIVE ANY OF THE FOLLOWING?

WIC: YES NO SNAP: YES NO FREE LUNCH/BREAKFAST PROGRAM: YES NO

LIHEAP: YES NO

**** This application will not be approved without proof of income and supporting documentation. Please attach copies of all financial information that applies. Please return within 60 days of discharge.**

- Current Check Stubs
- Tax Return and W2 forms for previous year
- Letter of Support, Room and Board
- Unemployment Letter
- Summary of Lind Benefits from DHS
- Social Security Earned Statement
- Court Orders
- Assistance from organization, i.e., Township, Church, Catholic Charities if Self-employed, Record of current earnings and previous year taxes

INSURANCE SECTION:

Do you have medical insurance? YES NO

Patient/Applicant Insurance Company: _____

Address: _____

Group #: _____ Policy #: _____ Phone: _____

Spouse/Partner Insurance Company: _____

Address: _____

Group #: _____ Policy #: _____ Phone: _____

BASED UPON THE INFORMATION RECEIVED WITH THIS APPLICATION, IF THE PATIENT IS DETERMINED TO BE PRESUMPTIVE ELIGIBLE, NO ADDITIONAL INFORMATION IS REQUIRED.

I CERTIFY THAT THE INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL APPLY FOR ANY STATE, FEDERAL, OR LOCAL ASSISTANCE FOR WHICH I MAY BE ELIGIBLE TO HELP PAY FOR THIS HOSPITAL BILL. I UNDERSTAND THAT THE INFORMATION PROVIDED MAY BE VERIFIED BY THE HOSPITAL, AND I AUTHORIZE 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 THE 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 THIS HOSPITAL BILL.

COMPLAINTS OR CONCERNS WITH THE HOSPITAL UNINSURED PATIENT DISCOUNT PROCESS MAY BE REPORTED TO THE HEALTH CARE BUREAU OF THE ILLINOIS ATTORNEY GENERAL AT 1-877-305-5145 OR https://illinoisattorneygeneral.gov/consumers/hcform.pdf

Patient/Applicant: _____ Date: _____

Spouse/Partner: _____ Date: _____

SILVER CROSS HOSPITAL
Patient Accounts
PH: 815-300-7087
FAX: 815-300-4954
EMAIL: businessoffice@silvercross.org