Patient Financial Help

Keep these 2 pages for your own information and records.

You may be able to get Free or Discounted Care: Filling out this application will help the University of Chicago Medicine know if you can get free or discounted services or other public programs to help pay for your healthcare.

If you are not insured, a social security number is not needed to get free or discounted care. A social security card is needed for some public programs, including Medicaid. You do not need to give a social security number in this application. But it will help the hospital know if you can get financial help from public programs.

You can apply for free or discounted care within 90 days after the date of discharge or after having outpatient care. To apply, fill out this form and give it to the hospital in person, by mail, by electronic mail (e-mail), or by fax.

By signing this form, you are saying you have made every possible effort to provide all information asked for to know if you are able to get financial help.

To Apply for Financial Help: Complete pages 1 to 4 of the attached application.

Documents You Must Send	
1. Completed and signed Application for Patient Financial Assistance (help)	
2. Copy of Driver's License or State ID for patient and Guarantor (person responsible for patient's bill.)	
3. Any one of the following: (only 1 is needed)	
• A copy of the most recent tax return	
• A copy of the most recent W-2 forms and 1099 forms	
• Copies of the 2 most recent pay stubs	
• Written proof of income from an employer if paid in cash	
• 1 other kind of third-party proof of income that is accepted by the hospital.	

Sign the application and return it with required documents	
Send as soon as possible to:	The University of Chicago Medicine 150 Harvester Drive, Suite 300 Burr Ridge, IL 60527-5965 **Email:** FinAssistance@uchicagomedicine.org **Fax: 773-834-0352**

If You Are Approved for Financial Assistance

When we get your completed application with the required documents:

- We will let you know within 10 business days if you can get financial help.
- **If you are approved for financial help:**
  - Ingalls Memorial Hospital (Ingalls) will share that you are approved for financial help with healthcare providers who provide services covered by Ingalls Financial Assistance Policy. This is so you can get the same discount on your hospital bill and on any bill from your doctor.
  - **Remember:** some services, including from a doctor, may have separate bills.

Patient Financial Help

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Important: The patient **does not need to fill out the Monthly Expenses on page 3** of the Application for Patient Financial Assistance **if**:

- The patient meets **Section 4500.40 Presumptive Eligibility Criteria** below (any of the items in the list below apply to the patient) **or**
- They can get financial help based on the patient's family income.

Section 4500.40 Presumptive Eligibility Criteria

Patients at UChicago Medicine are presumed eligible for hospital financial help if any of the following apply to the patient. This means the patient can get access to healthcare during the time their application is being reviewed. The patient does not have to wait until their application is approved to get healthcare.

1. Is homeless
2. Is deceased (dead) with no estate (has not left behind anything of financial value)
3. Has mental incapacitation (a mental disability keeps the patient form being able to make decisions on their own) and there is no one to act for the patient
4. Can get Medicaid, but not for the date of service, or Medicaid will not pay for the service
5. Takes part in any of these programs for person's with low income (person's income is at or below 200 percent of federal poverty income guidelines):
   - Women, Infants and Children Nutrition Program (WIC)
   - Supplemental Nutrition Assistance Program (SNAP)
   - Illinois Free Lunch and Breakfast Program
   - Low Income Home Energy Assistance Program (LIHEAP)
   - Organized community-based program that provides access to medical care. Program shows proof that person meets low-income financial status to get benefits.
   - Gets a financial grant for medical services

Important Phone Numbers

For question about your bill and financial help	**(708) 333-1100**
All other questions: University of Chicago Medicine Operator	**(773) 702-1000**

Complaints or Concerns about this application or the hospital financial help process may be reported to the Health Care Bureau of the Illinois Attorney General.

Call **1 (877) 305-5145.**

Application for Patient Financial Assistance

Patient Sticker

Patient Information

Patient Name:

Date of Birth:

Address:

City:	State:	Zip code:

Home Phone:	Cell Phone:

Email:

Patient Social Security Number: _____

You must give a Social Security Number for some public programs, including Medicaid.

If you do not have health insurance, you do not need a social security number to get free or discounted care. But giving your Social Security Number helps the hospital know if you can get any of these public programs.

Questions for Patient

Did the patient live in Illinois (resident) at the time of service?	☐ Yes ☐ No
Was the patient in an accident that led to the need for services?	☐ Yes ☐ No
Was the patient a victim of a crime that led to the need for services?	☐ Yes ☐ No
How many people live in the patient's household?	
How many people are dependents of the patient? (A dependent is anyone under 18 or anyone listed as a dependent on another person's federal tax return.)	
If the patient has dependents, what are the ages of the dependents?	

Responsible Person or Guarantor Information: A guarantor is an organization or person (not the patient) who is financially responsible for the patient's medical bills.

Responsible Person or Guarantor Name:

Relationship to the Patient:

Phone Number:	Cell Phone:

Address:

City:	State:	Zip code:

Email:

Application for Patient Financial Assistance

Patient Sticker

Patient's Employer and Place of Work

Name of Employer:		
Phone Number	Cell Phone	
Address:		
City	State:	Zip Code:

Responsible Party or Guarantor's Employer and Place of Work

Name of Employer:		
Phone Number:	Cell Phone:	
Address:		
City:	State:	Zip Code:

Total Monthly Family Income From All Sources Amount you earn before any deductions or taxes are taken out. **Total amount must include income of patient and any spouse or partner.**	**Total Amount**
Patient's Monthly income	
Monthly income of Patient's spouse or partner	
Monthly income of Patient's Parents or Guardians	
Self-employment Income	
Unemployment Compensation	
Social Security Income	
Social Security Disability	
Veteran's Pension	
Veteran's Disability	
Private Disability	
Workers' Compensation	
Temporary Assistance for Needy Families	
Retirement Income	
Child Support	
Alimony or Other Spousal Support	
Other Income	
Monthly Wages of Other Guarantor Name of Other Guarantor: _____	

Application for Patient Financial Assistance

Patient Sticker

Value of All Financial Assets	Total Amount
Checking Accounts	
Savings Accounts	
Stocks	
Certificates of Deposit	
Mutual Funds	
Health Savings or Flexible Spending Account	
Car or other vehicle (Make and Year)	
Car or other vehicle (Make and Year)	
Car or other vehicle (Make and Year)	
Real Estate you own (such as a house or land). Please describe:	
Real Estate you own (such as a house or land). Please describe:	
Other Assets: (Please describe)	

Monthly Expenses (what these cost each month)

Patient does not need to complete this part if they meet Section 4500.40 Presumptive Eligibility Criteria or if they can get financial help based on the patient's family income.
See page 2.

	Total Amount
Housing (monthly rent or mortgage)	
Utilities (gas, electric, water, phone....)	
Food	
Transportation (public transit cost or cost for gas, insurance, parking)	
Child Care	
Loans (payment on loans you have)	
Medical Expenses (premiums, medical equipment, prescriptions)	
Other Expenses	
Total Monthly Expenses	

Application for Patient Financial Assistance

Patient Sticker

List all insurance coverage you have for the services you were given

Insurance Type	Insurance Name	Policy Number	Group Number
Health Insurance			
Medicare			
Illinois Medicaid			
Other Medicaid			
Medicare Supplement			
Medicare Part D			
Veterans' Benefits			
Workmen's' Comp			
Personal Injury and Liability			
Auto Insurance			
Other kinds of Insurance			

Certification

By signing below, the Patient or Guarantor is saying they have provided all information asked for in this application. This is to help UChicago Medicine know if the patient can get financial help.

By signing my name, I am saying (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 financial help that may help me pay this hospital bill.
- I give my permission for UChicago Medicine to contact other organizations to check that the information in this application is true and correct.
- I know that if I provide information in this application that is not true and correct, I will not be given financial help. Any financial help given to me may be taken away, and I will be responsible for payment of any bills.

Patient Printed Name: _____

Signature: _____ **Date:** _____ **Time:** _____

Guarantor Printed Name: _____

Signature: _____ **Date:** _____ **Time:** _____