Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help UChicago Medicine AdventHealth (UCM-AH) determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to UCM-AH.

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 us determine whether you qualify for any public programs.

Please complete this form and submit it to us in person, by mail, or by electronic mail to apply for free or discounted care within 240 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist UCM-AH in determining whether the patient is eligible for financial assistance.

Instructions: All fields must be completed unless noted otherwise. **Medical Record Number**: _____

Patient Information

Last Name, First Name

_____

Date of Birth

_____

Street Address

_____

City, State, Zip Code

_____

Social Security Number (optional)

_____

Email Address

_____

Home Phone Number

_____

Alternate Phone Number

_____

Race (Optional – Asian, Black, Multiple, White, etc)

_____

Ethnicity (Optional – Not Hispanic, Cuban, Mexican, etc)

_____

Legal Sex (Male/Female/Unknown)

_____

Preferred Language

_____

Employment Status

_____

Employer Name

_____

Employer Street Address

_____

Employer City, State, Zip Code and Phone Number

_____

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Was the patient an Illinois resident at the time care was rendered? ..... □ Y □ N

Were you a victim of an accident or crime? ..... □ Y □ N

Does the patient have any of the following: Health insurance, Medicare, Medicare Part D, Medicare Supplement, Medicaid, and/or Veterans' benefits? ..... □ Y □ N

If yes, which one and what is the policy/member number: _____

Is someone other than the patient financially responsible for medical care based on former spouse/partner/ dissolution proceedings, if divorced or separated? (Documentation required) ..... □ Y □ N

Guarantor Information

Last Name, First Name

_____

Date of Birth

_____

Street Address

_____

City, State, Zip Code

_____

Social Security Number (optional)

_____

Telephone Number

_____

Employment Status

_____

Employer Name

_____

Employer Street Address

_____

Employer City, State, Zip Code and Phone Number

_____

Source of Income (examples include wages, self-employment, unemployment compensation, Social Security, Social Security Disability, veterans' pension, veterans' disability, private disability, workers' compensation, Temporary Assistance for Needy Families, retirement income, child support, alimony, or other spousal support, other income)

_____

Gross Monthly Family Income for Last 12 Months

_____

Number of Persons in Patient's Family/Household

_____

If income is $0, please select one of the following:

□ Disabled
□ Retired
□ Lives with relative(s)
□ Lives with friend(s)
□ Homeless
□ Unemployed

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Number of Dependents

_____

Ages of Dependents

_____

Vehicles in Household including Cars/Boats/RV

_____

Checking/Savings Account Balances

_____

Real Properties Owned and Values

_____

Stocks/CDs/Mutual Funds

_____

Health Savings/Flexible Spending Accounts

_____

Monthly Expense/Estimated Expense Information

Section A – Presumptive Eligibility

Refer to the table below for information on Presumptive Eligibility criteria. If the patient, or their family unit, meets any of the criteria listed below, the information requested in Section B is not needed. If the patient, or their family unit, does not meet any of the Presumptive Eligibility criteria listed below, proceed to complete Section B. *If Presumptive Eligibility criteria is not met, and Section B is incomplete, the Monthly Expense/Estimated Expense Information section of this application will be considered incomplete.*

Criteria	**Indicate Response**	**Supporting Information Required**
Women, Infants and Children Nutrition Program (WIC)	☐ Yes ☐ No	Documentation showing the patient is eligible
Supplemental Nutrition Assistance Program (SNAP)	☐ Yes ☐ No	
Illinois Free Lunch and Breakfast Programs	☐ Yes ☐ No	
Low Income Home Energy Assistance Program (ILHEAP)	☐ Yes ☐ No	
Grant Assistance for medical services *Specify Program Name:* _____	☐ Yes ☐ No	
Community Based program providing access to medical care *Specify Program Name:*_____	☐ Yes ☐ No	Letter from program confirming eligibility
Medicaid eligibility, but not on the date of service or for non-covered service	☐ Yes ☐ No	No additional documentation needed.
Personal bankruptcy	☐ Yes ☐ No	Case Number: _____ Discharge Date: _____
Mental incapacitation with no one to act on patient's behalf	☐ Yes ☐ No	Written statement from patient's physician or family
Deceased with no estate	☐ Yes ☐ No	Copy of patient's death certificate
Incarcerated	☐ Yes ☐ No	No additional documentation needed.
Homelessness	☐ Yes ☐ No	Shelter address _____ Shelter phone number _____

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Section B – Detailed Information Requested

Housing _____

Utilities _____

Food _____

Transportation _____

Child care _____

Loans _____

Medical expenses _____

Other expenses _____

Patient Certification and Signature

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 of 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 UCM-AH 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 bill.

Patient or Applicant Signature _____

Date Completed _____

How to Submit Your Application

	UChicago Medicine AdventHealth Bolingbrook	**UChicago Medicine AdventHealth GlenOaks**	**UChicago Medicine AdventHealth Hinsdale**	**UChicago Medicine AdventHealth La Grange**
In Person	500 Remington Boulevard Bolingbrook, IL 60440	701 Winthrop Avenue Glendale Heights, IL 60139	120 North Oak Street Hinsdale, IL 60521	5101 South Willow Springs Road La Grange, IL 60525
Mail	AdventHealth, Attn: Financial Assistance, PO Box 935979, Atlanta, GA 31193			
Email	Financialassist@medsrv.co (only two letters after the period in the email address)			
Patient Portal	https://account.adventhealth.com/login or AdventHealth App			
Questions?	800-462-0490			

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. The Health Care Bureau's toll-free hotline is 1-877-305-5145 (TTY 1-800-964-3013). Electronic forms for Health Care Complaints are also available in the Filing a Health Care Complaint section of the Office of the Illinois Attorney General website at https://illinoisattorneygeneral.gov/.