Deaconess Illinois

FINANCIAL ASSISTANCE APPLICATION

Your application is not complete without proof of income and assets. Please do not send original documents, as we are unable to return these to you. If you report $0 income, please provide a brief explanation of how you are meeting your monthly expenses. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help the hospital determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please submit this application to the hospital.

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 as soon as possible from your discharge or receipt of outpatient care. The Hospital does not have a time limit for submission.

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.
YOU MUST PROVIDE PROOF OF GROSS HOUSEHOLD INCOME AND ASSET INFORMATION. THIS MAY BE IN THE FORM OF:

INCOME: (One of the Following)

1. **LAST TWO (2) PAY STUBS**
2. **COPY OF MOST RECENT W2 AND 1099 FORMS**
3. **MOST RECENT TAX RETURN FORM**
4. **WRITTEN INCOME VERIFICATION FROM EMPLOYER IF PAID IN CASH**
5. **OTHER THIRD-PARTY VERIFICATION (CHILD SUPPORT PAYMENTS; SSI AWARD LETTER)**

ASSETS
RECENT BANK STATEMENTS SUPPORTING VALUE LISTED FOR CHECKING/SAVINGS ACCOUNTS

Please print all information using BLACK ink only

PATIENT INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City	State	Zip Code	
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____	Email:			

RESPONSIBLE PARTY'S INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City	State	Zip Code	
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____	Email:			

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RESPONSIBLE PARTY'S SPOUSE INFORMATION

First Name	Middle Name	Last Name	
Social Security Number	Birth Date	Sex M F	Telephone No.

Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled
☐ Unemployed -- Last date worked: _____

DEPENDENTS (List self, spouse and legal dependents)

Name	Age	Relation	Name	Age	Relation
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ASSETS (Must provide proof of value) dollar amount:

Savings Account _____
Checking Account _____
Home Value _____
Other Real Estate _____

TOTAL _____

Vehicle Information

Make & Model	Year	Value
1.		
2.		
3.		

GROSS MONTHLY INCOME (Need proof of Income)

Applicant _____
Applicant Spouse _____
Social Security Income _____
V.A. Pension _____
Pension _____
Unemployment _____
Worker's Compensation _____
Interest Income _____
Dividend Income _____
Child Support _____
Alimony _____
Income from Rental Property _____
Other _____

TOTAL _____

I qualify for public assistance. ___ Yes ___ No

DEBTS	dollar amount:
Home Loan Balance	
Car Loan Balance	
TOTAL	

MONTHLY PAYMENTS	
Mortgage	
Rent	
Utilities (Electricity, Water, Gas) etc.	
Transportation Costs	
Food	
Car Payment	
Child / Elder Care	
Child Support	
Alimony	
TOTAL	

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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 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 hospital bill.

I, (your name) _____,
do solemnly state that the information contained on this application is true and accurate to the best of my knowledge and belief.

_____
Signature of Patient, Parent, Spouse or Legal Representative

_____
Date

Concerns or complaints with the financial assistance process may be reported to the Health Care Bureau of the Attorney General (below).
www.illinoisattorneygeneral.gov/File-A-Complaint

KWAME RAOUL
ILLINOIS ATTORNEY GENERAL
Health Care Bureau
100 West Randolph Street
Chicago, IL 60601
Hotline Number: 1-877-305-5145 *** Fax Number: 1-312-793-0802 *** TTY: 1-312-964-3013
Website: www.IllinoisAttorneyGeneral.gov Email: HealthCare@ilag.gov

Please Note: If a patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expenses information and estimated expense figures.