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 OTHER PUBLIC PROGRAMS THAT CAN HELP PAY FOR YOUR HEALTH CARE. PLEASE SUMBIT 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 SOCAL 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.

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 PATIENT'S MEDICAL CARE DUE TO A DISSOLUTION/SEPERATION 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	$________________	$_____________
WORKMANS 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 SECURTY EARNED STATEMENT
COURT ORDERS
ASSISTANCE FROM ORGANIZATION, IE 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 CERIFY 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