REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAM: FINANCIAL STATEMENT

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Rush University Medical Center and/or Rush Oak Park Hospital 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 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 program, 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 90 days following the date of discharge or receipt of outpatient care.

If you meet the presumptive eligibility criteria, for example, enrolled in an assistance program for low-income (WIC, SNAP, Il Free Lunch Program, etc) or have an income at or below 200% of the federal poverty guidelines, you are not required to complete this application.

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.

1) Patient Information

PATIENT NAME: _____
Last First Middle Int.

ADDRESS: _____
Number and Street Apt.

_____
City State Zip Code

PHONE: HOME ( ) _____ CELL ( ) _____

EMAIL ADDRESS: _____

DATE OF BIRTH:____/____/____

SOCIAL SECURITY NUMBER (not required if you are uninsured):_____-_____-_____

If the patient's current or former spouse or partner is the guarantor for the patient, or if a parent or guardian is guarantor for a minor patient, please provide the following:

Guarantor Name: _____

Guarantor Address: _____

Guarantor Phone Number: ( ) _____

Was the patient an Illinois resident when care was rendered by the hospital? Yes ☐ No ☐
Was the patient involved in an alleged accident? Yes ☐ No ☐
Was the patient a victim of an alleged crime? Yes ☐ No ☐

Additional Information (Optional)

This section is a requirement of the State of Illinois. Responses or nonresponse will not have any impact on the outcome of your application. Please check appropriate responses below.

SEX (Legal):

Male: ☐
Female: ☐
Non-binary: ☐
Other: _____
Prefer not to say: ☐

PREFERRED LANGUAGE:

English: ☐
Spanish: ☐
Other: _____
Prefer not to say: ☐

ETHNICITY:

Hispanic or Latino: ☐
Not Hispanic or Latino: ☐
Prefer not to say: ☐

RACE:

American Indian or Alaska Native: ☐
Asian: ☐
Black or African American: ☐
Native Hawaiian or Other Pacific Islander: ☐
White: ☐
Other: _____
Prefer not to say: ☐

2) Family Information

Number of persons in the patient's family or household. _____

Number of persons who are dependents of the patient.* _____

(*Number of individuals for whom the patient is financially responsible)

Ages of the patient's dependents:_____,_____,_____,_____,_____,_____,_____, _____

3) Family Employment and Income Information

Is the patient, patient's spouse or partner, or (in the case of a minor patient) the patient's parents or guardians currently employed? Yes ☐ No ☐

If yes, name of employer: _____ Phone ( ) _____

Name of second employer: _____ Phone ( ) _____

Name of third employer: _____ Phone ( ) _____

4) Gross monthly family income:

Please enclose your most recent federal tax return. In addition, please include the most recent documentation of family income, such as 2 months of paycheck stubs, benefits statements, award letters, court orders, or other documentation. *Family income* includes patient, spouse or partner income, or (in the case of a minor patient) income earned by the patient's parents or guardians from the following sources:

Estimated Monthly Income

- Wages Earned…… _____
- Self-employment ……... _____
- Unemployment Compensation ……... _____
- Social Security ……... _____
- Social Security disability …….. _____
- Veterans' pension …… _____
- Veterans' disability …… _____
- Private disability ……... _____
- Workers' Compensation …….. _____
- Temporary Assistance for Needy Families (TANF) ……. _____
- Retirement income …….. _____
- Child support, alimony or other spousal support…….. _____
- Other income…….. _____

5) Asset and estimated asset value information

Asset Value

- Checking Account…… _____
- Savings ……..... _____
- Stocks ……..... _____
- Certificates of Deposit …… _____
- Mutual Funds …… _____
- Credit Union Account…… _____
- Health savings/Flexible Spending Account…….. _____

6) Insurance / benefit information:

Is the patient covered under any insurance plan? Yes ☐ No ☐

If yes, check plan:

☐ Medicare ☐ Medicare Part D ☐ Medicare Supplement
☐ Medicaid ☐ Veterans' benefits
☐ Health insurance: Name of plan: _____

7) Certificate Statement:

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 and/or physician 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 bill. 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 via https://illinoisattorneygeneral.gov/consumers/hcform.pdf or by calling 1-877-305-5145.

_____
Applicant Name (Printed)

_____ ____/___/_____
Patient or Applicant Signature Date