Required Supporting Documentation

Please provide the documentation outlined below. Failure to do so may result in a delay or denial of your application. If you cannot provide the documentation, please provide a letter of explanation.

- ☑ Fully completed and signed Application for Financial Assistance
- ☑ Valid Photo ID (Driver's license, Passport, State-issued ID or Valid government issued ID)
- ☑ Proof of Illinois Residency *(Provide **at least one** of the following if a valid IL Driver's License or IL State issued ID is not available)*
  - ☐ Rent receipt or lease
  - ☐ Recent utility bill with Illinois address
  - ☐ Mail from a government or other credible source
  - ☐ Letter from a homeless shelter
  - ☐ Voter registration card
- ☑ Tax Documents *(Provide the following)*
  - ☐ Most recent federal tax return (including all schedules)
  - ☐ **AND** most recent W-2 and 1099 forms
- ☑ Proof of Family Income *(Provide the following for the patient/guarantor and for each member of the patient/guarantor's household including spouse or partner)*
  - ☐ Copies of most recent pay stubs – 2 months (Employer, Unemployment, Social Security)
  - ☐ Written income verification if paid in cash
- ☑ Proof of Assets *(Provide all applicable documents for the assets listed below)*
  - ☐ Checking/Savings Account(s)
  - ☐ Stocks
  - ☐ Certificates of Deposit
  - ☐ Mutual Funds
  - ☐ Health Savings/Flexible Spending Account(s)
  - ☐ Credit Union Account(s)

Supplemental/Other:

- ☑ Completed and signed "Authorization to Release Information" form if you have filed a lawsuit related to your illness, accident or work-related injury.
- ☑ Primary Residency? Own ☐ Rent ☐ Other _____
- ☑ Secondary Residency? Own ☐ Rent ☐ None ☐ Other _____

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 60 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 ☐

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 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.

_____ ____/____/____
Patient or Applicant Signature Date

_____ ____/____/____
Rush Financial Counselor/Representative Date