RUSH

Financial Assistance Application

Today's Date_____

Patient Name_____ Medical Record Number_____

IMPORTANT: You may be able to receive free or discounted care.
Completing this application will help Rush University Medical Center, Rush-Copley Medical Center, or Rush Oak Park Hospital (Rush) 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 Rush.

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 Rush determine whether you qualify for any public programs.

Please complete this form and submit it to Rush in person, by mail, by email, or by fax to apply for free or discounted care **within 240 days following the date of discharge or receipt of outpatient care.** Please submit your application with all required supporting documents for review.

Please see page 5 of this application for information on how to contact Rush if you need help completing this application, have questions or need more information regarding the financial assistance application or policy, and for information on where to return the application.

You acknowledge that you have made a good faith effort to provide all information requested in the application to assist Rush in determining whether you are eligible for financial assistance.

Patient Information				
Name	Social Security Number		Date of Birth	
Home Address	City		State	Zip Code
Home Phone Number	Cell Phone Number	Email Address		
Preferred Method of Contact ☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone		Annual Household Income		
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow or Widower				
Number of People in Household	Number of Dependents of the Patient	Age of Patients Dependents		
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed Last Day of Work				
Employer Name			Phone Number	
Employer Address	City		State	Zip Code
Name of health insurance plan employer offers, including COBRA			☐ Employer does not offer health insurance	

Spouse, Partner, Parent or Guarantor (where applicable)			
Name	Social Security Number	Date of Birth	
Home Address	City	State	Zip Code
Home Phone Number	Cell Phone Number	Email Address	
Relationship ☐ Spouse ☐ Partner ☐ Parent ☐ Guarantor ☐ Other			
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed Last Day of Work			
Employer Name		Phone Number	
Employer Address	City	State	Zip Code
Name of health insurance plan employer offers, including COBRA		☐ Employer does not offer health insurance	

Insurance Coverage		
Are you covered or eligible for any health insurance policy? ☐ Yes ☐ No If yes, check plan ☐ Medicare ☐ Medicare Supplement ☐ Medicare Part D ☐ Veterans' Benefits ☐ Illinois Medicaid ☐ Out of State Medicaid ☐Other:		
Name of Policy Holder	Insurance Plan	Policy Number
Name of Policy Holder (if second policy)	Insurance Plan	Policy Number

Questionnaire	
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 If yes, ☐ Automobile Accident ☐ Workplace Injury ☐Other:	
Have you hired an attorney or are you pursuing a claim for your injury or illness? ☐ Yes ☐ No If yes, please provide:	
Attorney Name	Attorney Phone Number
Was the patient a victim of an alleged crime? ☐ Yes ☐ No	
Additional Information (Optional) Illinois law requires the inclusion of this section on this application. Responses or nonresponses will not have any impact on the outcome of your application.	
Sex (Legal) ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to Say ☐ Other	
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Say	
Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African America ☐ Native Hawaiian /Other Pacific Islander ☐ White ☐ Prefer not to Say ☐ Other	
Preferred Language ☐ English ☐ Spanish ☐ Prefer not to Say ☐ Other	

Income Verification	
Please enclose your proof of family income. Acceptable family income documentation shall include any **one** of the following: (a) copy of the most recent tax return; (b) copy of most recent W-2 form and 1099 forms; (c) copies of the two most recent pay stubs; (d) written income verification from an employer, if paid in cash; or (e) a reasonable form of third-party income verification. *Family income* is the sum of a family's annual earnings for cash benefits from all income sources before taxes, less payments made for child support.	
	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	
Asset and Estimated Asset Value Information	**Asset Value**
Checking Account	
Savings	
Stocks	
Certificates of Deposit	
Mutual Funds	
Health Savings / Flexible Spending Account	

CERTIFICATION 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 Rush, and I authorize Rush 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 by calling 1-877-305-5145.

_____

Applicant Name (Printed)

_____ _____

Patient or Applicant Signature Date

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 requested documentation, please provide a letter of explanation.

□ Fully completed and signed Financial Assistance Application

□ Valid Photo ID (Driver's license, Passport, State-issued ID or other valid government issued ID)

□ Proof of Illinois Residency *(Provide **at least one** of the following if a valid IL Driver's License, IL State issued ID, or temporary visitor's driver's license is not available)*

- Lease Agreement
- Recent utility bill
- Mail from a government or other credible source
- Letter from a homeless shelter, transitional house, or other similar facility verifying residency
- Voter or vehicle registration card
- A statement from a family member of the patient who resides at the same address and presents verification of residency
- Any of the documents listed under the Family Income Verification section below

□ Family Income Verification *(Provide **any one** of the following:)*

- Copy of most recent tax return;
- Copy of most recent W-2 form and 1099 forms;
- Copies of two most recent pay stubs;
- Written income verification from an employer if paid in cash;
- A reasonable form of third-party income verification deemed acceptable by Rush

□ 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)

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 ☐ Other _____

Contacting Rush

If you need help completing this application, have questions or need more information regarding the financial assistance application or policy, or have questions about your estimate, please contact Rush at:

Rush University Medical Center	**Rush Copley Medical Center**	**Rush Oak Park Hospital**
Phone: (312) 942-5967 Email: financial_counselor@rush.edu	Phone: (630) 978-4990 Email: RC_Business_Office@rush.edu	Phone: (708) 660-5603 Email: financial_counselor@rush.edu

Please return your completed application to:

Rush University Medical Center	**Rush Copley Medical Center**	**Rush Oak Park Hospital**
1653 W. Congress Pkwy Rm. 415 Atrium Bldg. Attn: Financial Counselors Chicago, IL 60612 Upload: MyChart.rush.edu	Patient Financial Services Dept 2000 Ogden Avenue Aurora, IL 60504 Upload: MyChart.rush.edu	520 S. Maple Ave Registration Department Attn: Financial Counselor Oak Park, IL 60304 Upload: MyChart.rush.edu