RUSH

Rush Copley Medical Center

Dear Patient/Guarantor:

You are requesting an evaluation for free or discounted care under Rush Copley Medical Center's Financial Assistance/Charity Care program for your hospital bill(s). Consideration for assistance will be based on your financial status in comparison with the Income Guidelines as set forth by the US Department of Health and Human Services, published annually in the Federal Register.

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Rush Copley Medical Center 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 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 within 240 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.

Attach and submit the following backup information:

- **Most recent Federal and State Income Tax Return forms**
- **Two most recent paycheck or unemployment check stubs or a written statement of earnings from your employer for the previous two (2) months**
- **Forms approving/denying unemployment, workers compensation or assistance from the Department of Public Aid**
- **Statement of monthly benefits for Social Security or denial of benefits from Social Security**
- **Checking and Savings accounts statements from the previous two (2) months.**

All other sources of payment must be exhausted before financial assistance can be considered. Examples of other sources of payment include: all medical insurance, third party payers and liability claims, workman's compensation or other public programs.

If you are unable to provide any of the requested information, please attach a NOTARIZED letter explaining the details. If you are currently unemployed, please include the date you left employment, why you left, and the date you plan on returning to work.

If you meet the presumptive eligibility criteria defined in the regulations or because of your family income, you are not required to provide monthly expense information or estimated expense figures.

If you need help or for more information, please contact the Rush Copley Medical Center Patient Financial Services Department at 630-978-4990 during normal business office hours of 8:00 am to 5:00 pm, Monday through Friday.

FINANCIAL ASSISTANCE APPLICATION:

REQUIRED: ❶ Most recent Federal & State Income Tax Forms, ❷ Two most recent paycheck/unemployment check stubs or a written statement of earnings from your employer from the previous two (2) months, ❸ Forms approving or denying unemployment, workers compensation or assistance from the Department of Public Aid, ❹ Statement of monthly benefits from Social Security and ❺ Two Months Rent/Mortgage Receipts ❻ Checking and Savings accounts-statements from the previous two (2) months. Optional responses or no responses will not impact the outcome of the application.

Applicant's Name (Last, First, Initial)		
Applicant's Date of Birth	**Applicant's Social Security Number**	**Applicant's Home Phone Number**
Home Address (Include both Street Address and Mailing Address)		
City	**State**	**Zip Code**
Applicant's Place of Employment	**Applicant's Work Phone Number**	

Race (Optional)	Ethnicity (Optional)	Sex (Optional)	Preferred Language(Optional)

Gross Monthly Salary	Illinois Resident	E-Mail Address

Spouse's Name (Last, First, Initial)		
Spouse's Date of Birth	**Spouse's Social Security Number**	**Spouse's Home Phone Number**
Home Address (Include both Street Address and Mailing Address)		
City	**State**	**Zip Code**
Spouse's Place of Employment	**Spouse's Work Phone Number**	
Employer's Address (Mailing Address, City, State, Zip)		

Gross Monthly Salary	Illinois Resident	E-Mail Address

DEPENDENTS **(As defined by the United States Internal Revenue Services Guidelines)**

NAME	AGE	RELATIONSHIP	
1			
2			
3			
4			

OTHER SOURCES OF INCOME		
	Yourself/Monthly	Spouse/Monthly
Social Security Benefits		
Pensions/Disability Income		
Alimony /Child Support		
Worker's Compensation		
Unemployment Benefits		
Rental Income		

ASSETS	
Real Estate	Location: Own: Y or N Rental: Y or N Market Value of Property: $ Amount Owed on Property: $
Checking Acct	Bank Name & Address: _____ Account Number: _____ Current Balance: $ _____
Savings Acct	Bank Name & Address: _____ Account Number: _____ Current Balance: $ _____
Certificates of Deposit	Bank Name & Address: _____ Amount of CD: $_____ Maturity Date: _____
Stocks	_____ Value: _____
Mutual Funds/Bonds	_____ Value: _____
Health Savings/Flexible Spending	Company Name & Address: _____ Policy Number: _____ Available Cash Value: $ _____

MONTHLY EXPENSES			
Rent or House Payment	$	Utilities: Lights, Heat, & Water	$
Food	$	Transportation	$
Childcare	$	Loans	$
Medical Expenses	$		$
		TOTAL	$

OTHER DEBTS (Credit Cards, Medical, Educational)				
Name & Address of Creditor	What Purchased	Amount Financed	Unpaid Balance	Monthly Payment
1		$	$	$
2		$	$	$
3		$	$	$
4		$	$	$
5		$	$	$
			TOTAL	$

*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 full payment of the hospital 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 at their website:*https://illinoisattorneygeneral.gov/consumers/hcform.pdf.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____