THE UNIVERSITY OF CHICAGO MEDICINE

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

MRN:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help The University of Chicago Medicine (The 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 determine whether you qualify for any public programs.

Please complete this form and submit it to The Medical Center in person, by 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/Guarantor acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist The Medical Center in determining whether the patient is eligible for financial assistance.

Patient Name:_____ Patient Date of Birth: _____

Patient Address:_____ City/State/Zip: _____

Home Phone/Cell Phone: _____ Social Security Number: _____
(Not required if patient is uninsured)

Patient Email Address: _____

Was the patient an Illinois resident at the time of service?	Yes?_____ No? _____
Was the patient involved in an alleged accident that led to the need for services?	Yes?_____ No? _____
Was the patient a victim of an alleged crime that lead to the need for services?	Yes?_____ No? _____
Number of persons in the patient's family and/or household?	
Number of persons who are dependents* of the patient?	
What are the ages of the dependents* of the patient?	

*Dependent means a minor or any person who is listed as a dependent on another person's federal tax return.

Responsible Party/
Guarantor Name:_____ Phone/Cell: _____

Guarantor Address:_____ City/State/Zip: _____

Guarantor Email:_____ Guarantor Relationship to Patient: _____

At the time of service or later, was/is the patient divorced or separated or involved in a marital dissolution proceeding?
Yes?_____ No? _____

At the time of service or later, was/is the patient a dependent of a parent who is divorced or separated or involved in a marital dissolution proceeding? Yes?_____ No? _____

If so, then who is responsible for the patient's medical care per the divorce or separation agreement or order?
Name:_____ Relationship?_____ Home Phone/Cell: _____

Address:_____ City/State/Zip: _____

Patient
Employer Name:_____ Phone/Cell: _____

Employer Address:_____ City/State/Zip: _____
Parent/Guardian or
Spouse/Partner's Employer Name:_____ Phone/Cell: _____

Employer Address:_____ City/State/Zip: _____

Parent/Guardian Employer Name:_____ Phone/Cell: _____

Employer Address:_____ City/State/Zip: _____

LIST GROSS MONTHLY FAMILY INCOME FROM ALL SOURCES BELOW:

Gross Monthly Wages (patient)	$
Gross Monthly Wages (spouse/partner)	$
Gross Monthly Wages (parent/guardian)	$
Gross Monthly Wages (parent/guardian)	$
Self-employment Income	$
Self-employment Income	$
Unemployment Compensation	$
Social Security Income	$
Social Security Income	$
Social Security Disability	$
Veteran's Pension	$
Veteran's Disability	$
Private Disability	$
Workers' Compensation	$
Temporary Assistance for Needy Families	$
Retirement Income	$
Child Support	$
Alimony or Other Spousal Support	$
Other	$
Gross Monthly Wages of Other Guarantor.	$
Other Guarantor Name:	

LIST ASSETS AND ESTIMATED ASSET VALUE INFORMATION BELOW:

Checking Account	$
Savings Account	$
Stocks	$
Certificates of Deposit	$
Mutual Funds	$
Health Savings/Flexible Spending Account	$
Automobiles or other vehicles – Make/Year	$
Automobiles or other vehicles – Make/Year	$
Automobiles or other vehicles – Make/Year	$
Real Property - Describe	$
Real Property - Describe	$
Other	$
TOTAL	$
	$
	$

***LIST MONTHLY EXPENSES AND THEIR ESTIMATED COST BEL0W:**

Housing	$
Utilities	$
Food	$
Transportation	$
Child Care	$
Loans	$
Medical Expenses	$
Other Expenses	$
Other Expenses	$
TOTAL	$

*NOTE: If a patient meets the presumptive eligibility criteria established in Section 4500.40 or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

LIST ALL INSURANCE COVERAGES IN THE SECTION BELOW THAT ARE RELATED TO THE SERVICES RECEIVED:

Insurance Type	Insurance Name	Policy Number	Group Number
Health Insurance			
Medicare			
Illinois Medicaid			
Other Medicaid			
Medicare Supplement			
Medicare Part D			
Veterans' Benefits			
Workmen's' Comp			
Personal Injury/Liability			
Auto Insurance			
Other Insurance or Similar Coverage			

CERTIFICATION: 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 Medical Center, and I authorize them to contact third parties to verify the accuracy of the information provide 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 payment of the bill(s).

BY: _____ DATE: _____

REQUIRED DOCUMENTATION:

*Fully completed and signed Application for Patient Financial Assistance
*Copy of current Patient and/or Guarantor Driver's License or State ID
*Copy of federal tax return for the most recent year
*Documentation of family income – this may include paystubs, benefit statements, award letters, court orders, or other documentation

Completed application can be submitted for review by either mailing the application or faxing it to the locations below:

MAIL	FAX	IN PERSON
University of Chicago Medicine	773 702-1276	Financial Counseling
Patient Financial Services	ATTN: Patient Financial Services	Mitchell Bldg, Room TS200
Suite 300		CCD, 7th floor
150 Harvester Drive		
Burr Ridge, Il 60527-5965		

You will receive notification of determination within 10 business days of receipt of a complete application and all required documents. If you have any questions or need assistance in completing this application, please contact Patient Financial Services at (773) 702-5276.

If you are approved for assistance, The University of Chicago Medicine will share that information with The University of Chicago Physicians' Group and a like discount will be applied to any outstanding balances you may have.

IMPORTANT PHONE NUMBERS	
If you have a question about your University of Chicago Medicine Bill	773 702-6664
If you have a questions about your University of Chicago Physician Group Bill	773 702-1150
If you have a question about your Application for Patient Financial Assistance	773 702-5276
All other questions - University of Chicago Medicine Operator	773 702-1000