Patient Financial Assistance Information

Keep pages 1 and 2 for your own information and records.

You may be able to get Free or Discounted Care: Your application will help the University of Chicago Medicine know if you can get free or discounted services or other public programs to help pay for your healthcare.

How to Apply for Financial Assistance

Complete pages 3, 4, 5, and 6 of this application

Documents You Must Send	
A. Completed and signed Application for Patient Financial Assistance	
B. Copy of Patient and Guarantor Driver's License or State ID	
C. Copy of federal tax return for the most recent year	
D. Documentation of family income. This may include paystubs, benefit statements, award letters, court orders, or other documentation.	

Sign the application and return it with required documents

Send as soon as possible to:

The University of Chicago Medicine
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527-5965

If You Are Approved For Financial Assistance

When we get your completed application with the required documents we will let you know within 10 business days if you can get financial assistance.

If you are approved for financial assistance, The University of Chicago Medicine will share this information with The University of Chicago Physicians' Group. This is so you can get the same discount on your hospital bill and on any bill from your doctor.

Important Phone Numbers	
For question about your bill and financial assistance	**(884) 843-3594**
All other questions: University of Chicago Medicine Operator	**(773) 702-1000**

Application for Patient Financial Assistance

Important NOTE: In the Application for Patient Financial Assistance, the patient does not need to complete the **Monthly Expenses and Estimated Cost if**:

- The patient meets Section 4500.40 Presumptive Eligibility Criteria **or**
- It is believed they can get financial help based on the patient's family income.

If any of the items in the list below apply to the patient, you do not need to complete the Monthly Expenses and Estimated Cost.

Section 4500.40 Presumptive Eligibility Criteria

Patients at UChicago Medicine are believed to be able to get hospital financial assistance if the patient has one or more of the following.

1. Homelessness
2. Deceased with no estate
3. Mental incapacitation with no one to act on patient's behalf
4. Eligible for Medicaid, but not on date of service or for non-covered service
5. Enrolled in any of these assistance programs for low-income individuals:
    a. Women, Infants and Children Nutrition Program (WIC);
    b. Supplemental Nutrition Assistance Program (SNAP);
    c. Illinois Free Lunch and Breakfast Program;
    d. Low Income Home Energy Assistance Program (LIHEAP);
    e. Organized community-based program that provides access to medical care where the organization verifies limited low-income financial status to get benefits
    f. Grant assistance for medical services.

Application for Patient Financial Assistance

Patient Information

Patient Information		
Patient Name:		
Date of Birth:		
Address:		
City:	State:	Zip code:
Home Phone:	Cell Phone:	
Email:		

Patient Social Security Number: ______________________________

Note: You must have a Social Security Number for some public programs, including Medicaid. If you do not have health insurance you do not need a social security number to get free or discounted care. However, giving your Social Security Number will help us know if you can get any of these public programs.

Questions for Patient

Question	Answer
Was the patient an Illinois resident at the time of service?	☐ Yes ☐ No
Was the patient in a possible accident that led to the need for services?	☐ Yes ☐ No
Was the patient a victim of a possible crime that led to the need for services?	☐ Yes ☐ No
Number of people in the patient's family or household?	
Number of people who are dependents of the patient? (A dependent is anyone under 18 or anyone listed as a dependent on another person's federal tax return.)	
What are the ages of the dependents of the patient?	

Responsible Party or Guarantor Information (This is a person other than the patient who is financially responsible for the patient's medical bills)

Responsible Party or Guarantor Information		
Responsible Party or Guarantor Name:		
Relationship to the Patient:		
Phone Number:	Cell Phone:	
Address:		
City:	State:	Zip code:
Email:		

Application for Patient Financial Assistance

Patient's Employer and Place of Work		
Name of Employer:		
Phone Number	Cell Phone	
Address:		
City	State:	Zip Code:

Responsible Party or Guarantor's Employer and Place of Work		
Name of Employer:		
Phone Number	Cell Phone:	
Address:		
City:	State:	Zip Code:

Total Monthly Family Income From All Sources The amount you earn before any deductions or taxes are taken out.	**$ Amount**
Patient's Monthly Wages	
Monthly Wages of Patient's spouse or partner	
Monthly Wages of Patient's Parent or Guardian	
Monthly Wages of Patient's Parent or 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 Income	
Monthly Wages of Other Guarantor	
Name of Other Guarantor:	

Application for Patient Financial Assistance

Financial Assets and Estimated Value	$ Amount
Checking Account	
Savings Account	
Stocks	
Certificates of Deposit	
Mutual Funds	
Health Savings or Flexible Spending Account	
Automobile or other vehicle (Make and Year)	
Automobile or other vehicle (Make and Year)	
Automobile or other vehicle (Make and Year)	
Real-estate you own. (such as a house or land) Please describe:	
Real-estate you own. (such as a house or land) Please describe:	
Other Assets	

Monthly Expenses and Estimated Cost

NOTE: The patient does not need to complete this part if they meet Section 4500.40 Presumptive Eligibility Criteria or if is believed they can get financial help based on the patient's family income. See page 2.

	$ Amount
Housing	
Utilities	
Food	
Transportation	
Child Care	
Loans	
Medical Expenses	
Other Expenses	
Total Monthly Expenses and Estimated Cost	

Application for Patient Financial Assistance

List All Insurance Coverage You Have for Services You 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 and Liability			
Auto Insurance			
Other Insurance or Similar Coverage			

Certification

The Patient or Guarantor admits that they have provided all information asked for in this application. This in order to help UChicago Medicine know if the patient can get financial assistance.

By signing my name I am saying (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 financial help that I may be given to help pay for this hospital bill.

I give my permission for UChicago Medicine to contact other organizations to check that the information in this application is true and correct.

I understand that if I provide information in this application that is not true and correct, I will not be given financial help. Any financial help given to me may be taken away, and I will be responsible for payment of the bill(s).

Patient Printed Name:	Date:
Signature:	