

MRN:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help University of Chicago Medicine, Ingalls Memorial 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 University of Chicago Medicine, Ingalls Memorial 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 University of Chicago Medicine, Ingalls Memorial in determining whether the patient is eligible for financial assistance.

Patient Name:		Patient Date of Birth:	
Street w/Apt No.:	City:	State:	Zip:
Email:	Primary Phone:	Mobile Phone:	

Was the patient an Illinois resident at the time of service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the patient involved in an alleged accident that led to the need for services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the patient a victim of an alleged crime that led to the need for services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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.		

List all insurance coverage that are related to the services received			
Insurance Type	Insurance Name	Policy Number	Group Number
Health Insurance			
Medicare			
Medicare Supplement			
Medicaid			
Veterans' Benefits			
Workman's Compensation			
Personal Injury/Liability			
Auto Insurance			
Other Insurance			
Responsible Party/Guarantor Name:			Phone/Cell:
Guarantor Street:	City:	State:	Zip:
Guarantor Email:			Relationship to Patient:

Employment			
Primary Employer Name:		Phone:	
Street:	City:	State	Zip:
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:	Phone/Cell:
Street:		City:	State: Zip:

List encounters to be considered under the Financial Assistance Program <i>(Please include bill copies with application.)</i>					
Admit Date:	Discharge Date:	Type of Service:	Encounter No.:	Medical Record:	Balance Due
Total Outstanding Balance:					\$

List Income, Assets, Expenses & Debts			
Wages and Income <i>(Annual; Yearly)</i>		Expenses & Debts <i>(Monthly)</i>	
Wage – Applicant	\$ _____	Mortgage/Rent	\$ _____
Wage – Other Household Member(s)	\$ _____	UTIL: Gas/Electric	\$ _____
Social Security/Disability Benefit	\$ _____	UTIL: Phone/Mobile Phone	\$ _____
Retirement/Pension Benefit	\$ _____	Child Care	\$ _____
Alimony/Child Support	\$ _____	Food	\$ _____
Unemployment Benefit	\$ _____	Auto Insurance	\$ _____
Assets & Estimated Assets		Credit Card(s)	\$ _____
Checking, Savings, Stocks, Funds, etc.	\$ _____	Health Insurance	\$ _____
Health Savings/Flex Spending	\$ _____	Total Medical Expenses	\$ _____
Automobile(s)	\$ _____	Loan: Automobile(s)	\$ _____
Real Estate Property	\$ _____	Loan: School/Education	\$ _____
Other: _____	\$ _____	Other: _____	\$ _____

Certification	
<p>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).</p>	
Applicant Signature: _____	Date: _____

Required Documentation

A fully completed and signed Financial Assistance Application

AND

Any one or more of the following:

- Copy of most recent Tax Return
- Copy of most recent W-2 Form and 1099 Form(s)
- Copies of the 2 most recent pay stubs; or
- Written income verification from an employer if paid in cash.

If a patient is not able to provide any of the documents listed here, IMH will work with the patient to determine if there is an acceptable other means of documenting Family Income.

Completed applications and attachments can be submitted by:

Mail: University of Chicago Medicine, Ingalls Memorial
FAP Application Processing
One Ingalls Drive
Harvey IL 60426-9988

Fax: 708-225-7535

eMail: faprogram@ingalls.org