Financial Assistance Application

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. If you have any questions or concerns about the Financial Assistance Program or this Financial Assistance Application, please contact a Financial Counselor located near the main lobby of University of Chicago Medicine, Ingalls Memorial at One Ingalls Drive, Harvey IL 60426 or call 773-333-1100.

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

Additional Patient Information (Optional). Responses to these questions are OPTIONAL. Responses, or choosing not to respond, will not have any effect on whether the patient is eligible for financial assistance.

Race/Ethnicity:	Sex:
Preferred Language:	

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? Was	Yes	No
the patient a victim of an alleged crime that lead to the need for services?	Yes	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			
Medicaid			
Veterans' Benefits			

Workman's Compensation Personal Injury/Liability			
Auto Insurance			
Other Insurance			

Responsible Party for Non-Health Plan related Benefits

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 *(Please include bill copies with application.)*

Admit Date:	Discharge Date:	Type of Service:	Encounter No.:	Total Charges:	Balance Due
				Total Outstanding Balance:	$

Presumptive Eligibility

If a patient meets presumptive eligibility criteria established in connection with 77 I.A.C. 4500.40 (as further described below) or is otherwise presumptively eligible by virtue of the patient family income, the patient shall not be required to complete the portions of the application addressing monthly expense information and estimated expense figures set out in 77 I.A.C. 4500.30, subsection (g) (i.e. the portions of the application addressing monthly expense information and estimated expense figures relating to housing, utilities, food, transportation, child care, loans, medical expenses, and other expenses).

Applicant may be deemed presumptively eligible if they can demonstrate one or more of the following:

Homelessness

Deceased with no estate

Mental Incapacitation with no one to act on patient's behalf

Medicaid eligible, but not on date(s) of service

Enrollment in one or more of the following assistance programs:

WIC SNAP LIHEAP IL Free Lunch and Breakfast Program

Enrollment in an organized community based program providing access to medical care that assesses and documents lowincome financial status as a criterion for membership

Receipt of Grant assistance for medical services

List Income, Assets, Expenses & Debts

Wages and Income *(Annual; Yearly)*		**Expenses & Debts** *(Monthly)*	
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

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).

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

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 1-877-305-5145 (TTY 1-800-964-3013).