

Financial assistance application form

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Alexian Brothers Health System, d/b/a Ascension Illinois affiliates 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 address listed on the cover letter.

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 Alexian Brothers Health System, d/b/a Ascension Illinois affiliates determine whether you qualify for any public programs. For any application questions marked “optional,” your response (or non-response) will not have any impact on the outcome of the application.

Please complete this form and submit it to Alexian Brothers Health System, d/b/a Ascension Illinois affiliates in person, by mail, by electronic mail, or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your application for up to 240 days following the first billing statement for your care. By submitting this application, you acknowledge that you have made a good faith effort to provide all information request in the application to assist Alexian Brothers Health System, d/b/a Ascension Illinois affiliates in determining whether the patient is eligible for financial assistance. If you have any questions on the application process, you may contact Alexian Brothers Health System’s, d/b/a Ascension Illinois affiliates financial counseling department with questions or concerns at 833-272-7585.

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. The Health Care Bureau’s toll-free hotline is 1-877-305-5145 (TTY 1-800-964-3013).

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date _____ Account number _____

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Optional - Gender Identity – Do you think of yourself as: Male Female Transgender man/trans man/female-to-male (FTM)

Transgender woman/trans woman/male-to-female (MTF) Genderqueer/gender nonconforming neither exclusively male nor female

Additional gender category (or other)

Optional - Gender Identity: What sex was originally listed on your birth certificate?: Male Female

Optional - Race: White Black or African American American Indian or Alaska Native Asian Indian Chinese Filipino Japanese

Korean Vietnamese Other Asian Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander

Optional – Ethnicity: Hispanic, Latino/a, or Spanish origin Mexican, Mexican American, Chicano/a Puerto Rican

Cuban Another Hispanic, Latino/a or Spanish origin

Optional – Language - Do you speak a language other than English at home?: Yes No

If yes, which language?: _____

Mailing address _____ City _____ State _____ ZIP _____

Optional - Social Security number _____

Employer _____ Employment status _____

Employer phone number _____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Mailing address _____ City _____ State _____ ZIP _____

Social Security number (optional) _____

Employer _____ Employment status _____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Mailing address _____ City _____ State _____ ZIP _____

Social security number (optional) _____

Employer _____ Employment status _____

Employer phone number _____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____	Child support received _____
Applicant spouse income _____	Alimony received _____
Social security benefits _____	Rental property income _____
Pension/retirement income _____	Food stamps _____
Disability income _____	Trust fund distribution received _____
Unemployment compensation _____	Other income _____
Worker's compensation _____	Total gross monthly income \$ _____
Interest/dividend income _____	

Monthly living expenses

Patients who are presumptively eligible for financial assistance as described in Alexian Brothers Health System's, d/b/a Ascension Illinois affiliates Financial Assistance Policy are not required to complete this section.

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses \$ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Health savings/Flexible Spending Account vehicle _____

I authorize Alexian Brothers Health System, d/b/a Ascension Illinois affiliates to obtain information from external credit reporting agencies. 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 my medical bills. I understand that this information provided may be verified by Alexian Brothers Health System, d/b/a Ascension Illinois affiliates, and I authorize Alexian Brothers Health System, d/b/a Ascension Illinois affiliates 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 payment of the bill(s).

Signature of Applicant _____

Date _____

Comments _____

Dear Patient/Applicant,

Alexian Brothers Health System, d/b/a Ascension Illinois affiliates is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of 2 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

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Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received for the application to be considered. We are unable to process or consider incomplete applications.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail your completed application to the following address:

Alexian Brothers Health System
Attention: Financial Assistance Department
PO Box 74008855
Chicago, IL 60674-8843

If you have any questions about this application, please call one of our Patient Representatives at 833-272-7585.

Sincerely,

Patient Financial Services
Alexian Brothers Health
System, d/b/a Ascension
Illinois affiliates