Financial assistance application form

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help AMITA Health 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 AMITA Health 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 AMITA Health 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 AMITA Health in determining whether the patient is eligible for financial assistance. If you have any questions on the application process, you may contact AMITA Health's financial counseling department with questions or concerns at 888-693-2252.

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 _____
Applicant spouse income _____
Social security benefits _____
Pension/retirement income _____
Disability income _____
Unemployment compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food stamps _____
Trust fund distribution received _____
Other income _____
Total gross monthly income $ _____

Monthly living expenses

Patients who are presumptively eligible for financial assistance as described in AMITA Health's 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 AMITA 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 AMITA, and I authorize AMITA 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 _____

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To AMITA Health:

This letter is to advise that (patient's name)_____ receives little or no income and I am assisting with his/her living expenses. He/She/They has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____

Dear Patient/Applicant,

AMITA Health 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 3 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

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

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:

AMITA Health PFS
Attention: Financial Assistance Department
1000 Remington Blvd., Suite 110
Bolingbrook, IL 60440

If you have any questions about this application, please call one of our Patient Representatives at 888-693-2252.

Sincerely,

Patient Financial Services
AMITA Health