Advocate Health Care

Financial Assistance Application Patient account number:_____

**Important: *****You may be able to receive free or discounted care.* Completing this application will help Advocate Health Care determine if you are eligible to receive free or discounted services from Advocate or may qualify for public programs that can help pay for your healthcare. If you are uninsured, a social security number is not required to qualify for free or discounted care from Advocate. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number on this application is not required but will help Advocate determine whether you may qualify for any public assistance programs.

Please complete this application as soon as possible after the date of service in order for Advocate Health Care to determine your potential eligibility for financial assistance. We will accept your application for up to 240 days following the date of the first billing statement for the care.

For purposes of this application, Advocate Health Care defines Family as the patient, the patient's spouse/civil union partner, the patient's parents or guardians (in the case of a minor patient), and any dependents claimed on the patient's or parent's income tax return and living in the patient's or his or her parents' or guardians' household.

INSTRUCTIONS: Complete the application in full and sign the Application Certification to verify information.

PATIENT INFORMATION

Email Address					Family Size (include patient)
Last Name	First	M.I.		Date of Birth	Social Security Number
Street	Apt. #	City	State	Zip Code	Home Phone
Employer		Address			Cell Phone
City	State	Zip Code		Gross Monthly Income	Work Phone

Are you covered or eligible for any health insurance policy, including foreign coverage, Marketplace, COBRA, Veterans' benefits, Medicaid or Medicare? □ Yes (please provide information below) □ No, health Insurance not provided/available

Policy Holder:	Insurer:	Policy Number:
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Were you an Illinois resident when you received your care? □ Yes □ No

Have you applied for Medicaid? (we may require that you do so) □ Yes – Awaiting Approval □ Yes – Not Eligible □ No

Is the treatment provided related to any of the following? □ Accident □ Crime □ Workplace Injury □ Other:

Are you pursuing a third-party liability claim (auto, work comp, etc.…)? □ Yes (please provide information below) □ No

Attorney Name:_____Attorney Phone Number: _____

SPOUSE/GUARANTOR OR PARENT(S) OF MINOR			Relationship to Patient		Date of Birth
Email Address					Social Security Number
Last Name	First	M.I.			Home Phone
Employer		Address			Cell Phone
City	State	Zip Code		Gross Monthly Income	Work Phone

DEPENDENT HOUSEHOLD MEMBERS

Name	Age	Relationship

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HOSPITAL PREFERENCE

Please indicate which hospital you are scheduled at, or most likely to visit:

□ Christ Medical Center	□ Lutheran General Hospital
□ Condell Medical Center	□ Sherman Hospital
□ Good Samaritan Hospital	□ South Suburban Hospital
□ Good Shepherd Hospital	□ Trinity Hospital
□ Illinois Masonic Medical Center	□ Advocate Children's Hospital

PRESUMPTIVE ELIGIBILITY

Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below, whether individually or through the benefits provided to their Family, are automatically eligible to receive free care and do not need to supply any income, asset or expense information*. Advocate verifies eligibility electronically when possible but may need you to assist us to demonstrate your eligibility.

patient will still need to sign the Application Certification

□ WIC	□ SNAP	□ Illinois Free Lunch/Breakfast
□ Incarcerated	□ Homelessness	□ Grant Assistance for Medical Services
□ Deceased with no Estate	□ TANF: Temporary Assistance for Needy Families	□ LIHEAP: Low Income Home Energy Assistance Program
□ Community Based Medical Assistance Program	□ Mental Incapacitation with no one to act on patient's behalf	□ Illinois Housing Development Authority's Rental Housing Support Program
□ Affiliation with a religious order and vow of poverty	□ Medicaid eligibility but not on date of service or for non-covered services	□ Required information from verbal assessment

INCOME & ASSET INFORMATION

Please provide one or more of the following for each employed family member and sign the statement below:

1. A copy of most recent pay stub
2. A copy of most recent W-2 and 1099 forms
3. A copy of most recent tax return
4. A statement from your employer if paid in cash
5. Any other verification from a third party about your income (including award letters, benefit statements, court orders, etc.…)

INCOME CERTIFICATION

If you cannot provide any documentation relating to your income, fill out the statement below:

I_____(name), certify that I have no documents that prove my family's monthly income of $_____.

Received from:	Amount: $ _____	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Received from:	Amount: $ _____	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:

OTHER INCOME

In addition to income from your employment, you may receive income or support from another source (for example social security, disability, child support, alimony, unemployment or workers' compensation, veteran's pension or disability, TANF, retirement income, or other income). Please indicate the source and amount of income.

BANK ACCOUNTS/INVESTMENTS/ASSETS

Please list the total current balance for each of the following.

Checking/Savings/Credit Union Accounts:	$ _____	□ N/A
Other Investments (bonds, stocks, etc. excluding IRA and/or retirement accounts):	$ _____	□ N/A
Health savings or Flexible Spending account	$ _____	□ N/A
Automobiles or other vehicles	$ _____	□ N/A

PROPERTY

Please provide information regarding any property (buildings and/or land) that you own other than your primary residence.

What is the value of all buildings and land minus the amount owed on the property? Is this property used as income? □ Yes □ No	$ _____	□ N/A
What is the value of the land (without buildings) minus the amount owed on the property? Is this property used as income? □ Yes □ No	$ _____	□ N/A

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MONTHLY EXPENSE INFORMATION Please list your monthly expenses below. This information may help Advocate make a determination regarding your application, such as large outstanding bills which would show financial hardship. You may provide copies of these expenses (example: phone bills, electricity bills, medical bills, bank or checking statements, etc.) with your application.		
Housing/Mortgage/Rent	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Utilities (Electric, Heating/Cooling, Water, etc.)	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Food	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Transportation	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Dependent care	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Loans	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Medical Expenses	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:
Other Expenses	Amount: $	Frequency: □ Weekly □ Biweekly □ Monthly □ Other:

PATIENT INFORMATION - Optional

The following information is used for statistical purposes only. The following questions are OPTIONAL, and responses or nonresponses by the patient will not have any impact on the outcome of the application.

Applicant's Race:	**Applicant's Ethnic Group**	**Applicant's Sex**	**Applicant's Preferred Language**
□ American Indian or Alaskan Native	□ Hispanic/Latino Origin	□ Male	□ English
□ Asian	□ Not of Hispanic or Latino Origin	□ Female	□ Arabic
□ Black/African American	□ Unknown		□ Korean
□ Native Hawaiian			□ Polish
□ Other Pacific Islander			□ Russian
□ White			□ Simplified Chinese
□ Other			□ Spanish
			□ Other

Application 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 bill. I understand that the information provided may be verified by Advocate Health Care, and I authorize Advocate Health Care 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 Advocate's financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist Advocate Health Care in determining whether the patient is eligible for financial assistance.

Applicant Signature:_____ Date: _____

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Complete the following if you rely on someone else to provide daily living expenses:

STATEMENT OF SUPPORT

to be completed by the person providing assistance to the patient and/or patient's family

Patient Name: _____

Name of person providing for patient's needs:_____

Address for person above: _____

_____

Phone number: Home:_____Cell: _____

Relationship to patient: _____

I have been giving financial help to the patient since_____until_____.

I have provided:

- ☐ Room and Board (lodging and food)
- ☐ Clothing
- ☐ Payments for monthly expenses
- ☐ School Expenses
- ☐ Medication
- ☐ Transportation Expenses: car loan, car insurance, gas, etc.
- ☐ Other, please describe: _____

I can continue to provide the above for the named person but am unable to contribute toward his/her medical expenses.

_____ _____

Signature of person providing assistance Date

Submit completed Applications by:	**Need Assistance? We can help.**
Mail to: Advocate Health Care P.O. Box 3039, Oak Brook, IL 60522-9908; **Fax:** (630) 645-4691; **Email:** SRCO-FinancialAssistance@aah.org; or bring to a financial advocate	**Call** (847)795-2300 or visit a financial advocate

Complaints or concerns with the uninsured patient discount application process may be reported to the Health Care Bureau of the Illinois Attorney General. You can contact them at 1-877-305-5145.