

The University of Illinois Hospital & Health System

Is part of the University of Illinois at Chicago

Hospital Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help University of Illinois Hospital & Health Sciences System ("UI 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 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 the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 240 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

UI Health provides financial assistance for uninsured patients that meet certain requirements. UI Health determines the level of discount that you will receive based on your income in comparison to current federal poverty levels. UI Health's financial assistance programs are designed for uninsured patients and do not provide discounts on coinsurance, deductible or other out of pocket expenses for patients with third party insurance. Financial assistance applies to UI Hospital and most physician services. Please see the Financial Assistance Policy for more details.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Information** | | | | |
| Name Enter First Name MI Last Name. | | | | |
| Address Enter Address. | | | | |
| City Enter city. | | | State State | Zip Code Zip Code. |
| Home Phone # (###) ###-#### | Cell Phone # (###) ###-#### | | Email Click to enter email. | |
| Date of Birth Click or tap to enter a date. | | SSN*(not required if you are uninsured)* ###-##-#### | | |
| Was the patient an Illinois resident when care was rendered? Yes No | | | | |
| Was the patient involved in an accident? Yes No | | | | |
| Was the patient a victim of an alleged crime? Yes No | | | | |

|  |  |
| --- | --- |
| **Insurance Coverage** | |
| Are you covered or eligible for any health insurance policy, including foreign coverage, COBRA, Health Insurance Marketplace, Veterans' benefits, Medicaid and Medicare? Yes No  If yes, please provide the following information: | |
| Policy Holder Click or tap here to enter text. | Policy Holder Click or tap here to enter text. |
| Insurer Click or tap here to enter text. | Insurer Click or tap here to enter text. |
| Policy Number Click or tap here to enter text. | Policy Number Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guarantor Information (*if different from patient*)** | | | |
| Relationship Self Spouse Partner Parent Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(specify)* | | | |
| Name First Name MI Last Name. | | | |
| Address Click or tap here to enter address. | | | |
| City Click to enter city. | | State State | Zip Code Zip Code. |
| Home Phone # (###) ###-#### | Cell Phone # (###) ###-#### | | |

|  |
| --- |
| **Family/Household Information** |
| How many individuals live in the family/household? Choose an item. |
| How many individuals are dependents of the patient/guarantor? Choose an item. |
| What are the ages of the patient's dependents? Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Employment/Income Information** | | |
| Are you currently employed? Yes No | | |
| Is your spouse currently employed? Yes No | | |
| Employer Name Click or tap here to enter text. | | |
| Employer Address Click or tap here to enter text. | | |
| Employer City Click or tap here to enter text. | State State | Zip Code Zip Code. |
| Employer Phone # (###) ###-#### | | |
| Gross Monthly Family Income: Click or tap here to enter text.  (income before taxes and other deductions, including cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is guarantor for a minor, from all sources) | | |

|  |
| --- |
| **Optional Information**  Response/Nonresponse will not have any impact on application outcome |
| Ethnicity Click to select an ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(specify if other)* |
| Sex Male Female Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(specify)* |
| Preferred language: Click to select language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(specify if other)* |

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 hospital, and I authorize the hospital 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 hospital bill.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Signature | |  | | --- | |  | | |
| Patient Name First Name MI Last Name | | |
| Date Click or tap to enter a date. | | |
| Guarantor Signature | | |  | | --- | |  | |
| Guarantor Name First Name MI Last Name | | |
| Date Click or tap to enter a date. | | |

If you have any questions or concerns, please reach out to the Financial Case Management Unit at (312) 413 – 7621.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported the Health Care Bureau of the Illinois Attorney General at 1-877-305-5145 (TTY 1-800-964-3013).

Please provide any additional information below:

Click or tap here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| For Internal Use | Received on: | Received by: | Completed: | Last Update: 10/6/21 |

**Supporting Documents**

Please attach copies of the following documents:

Valid photo ID: State-issued ID, driver's license, passport

Proof of Illinois Residency: Provide at least one of the following documents

Valid state-issued photo ID or driver's license

Temporary visitor’s driver license

Recent utility bill with an Illinois address

Lease agreement

Vehicle registration card

Voter registration card

Current mail addressed to applicant from a government or other credible source

Statement from family member who resides at same address & presents residency verification

Letter from homeless shelter, transitional house, or similar facility

Proof of Income: Provide all applicable documents listed below

A copy of your most recent tax return (IRS 1040, 1040A, 1040EZ)

A copy of the most recent W-2 form and 1099 forms

Copies of the 2 most recent pay stubs (i.e, Employer, Unemployment, Social Security)

Written income verification from an employer if paid in cash

Proof of other sources of income (child support, alimony, other spousal support, veteran's benefits, etc.)

Statement of Financial Hardship

Please return completed documents including required attachments to:

Financial Case Management Unit

University of Illinois Hospital

1740 W. Taylor Street, Room 1155 (M/C 778)

Chicago, IL 60612-7232

Telephone: 312-413-7621

Fax: 312-413-3371

Email: getinsured@uic.edu