UI Health | UIC

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: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| Home Phone #: | Cell Phone #: | Email: | |
| Date of Birth: | 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<br>If yes, please provide the following information: | |
| Policy Holder: | Policy Holder: |
| Insurer: | Insurer: |
| Policy Number: | Policy Number: |

| Guarantor Information (*if different from patient*) | | | |
|---|---|---|---|
| Relationship ☐Self ☐Spouse ☐Partner ☐Parent ☐Other: _____*(specify)* | | | |
| Name: | | | |
| Address: | | | |
| City: | | State: | Zip Code: |
| Home Phone #: | Cell Phone #: | | |

| Family/Household Information |
|---|
| How many individuals live in the family/household? |
| How many individuals are dependents of the patient/guarantor? |
| What are the ages of the patient's dependents? |

| Employment/Income Information | | | |
|---|---|---|---|
| Are you currently employed? ☐Yes ☐No | | | |
| Is your spouse currently employed? ☐Yes ☐No | | | |
| Employer Name: | | | |
| Employer Address: | | | |
| Employer City: | | State: | Zip Code: |
| Employer Phone #: | | | |
| Gross Monthly Family Income:_____<br>(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) | | | |

| **Assets**<br>Asset and estimated asset value |
|---|
| Checking Account: |
| Savings Account: |
| Stocks: |
| Certificates of Deposit: |
| Mutual Funds: |
| Automobiles or other vehicles: |
| Health Savings/Flexible Savings Account: |
| Real Estate Property: |

If a patient meets the presumptive eligibility criteria, as set forth in this application, or is otherwise presumptively eligible by virtue of the patient's family income, the patient is not required to complete the portion of this application addressing the monthly expense information.

| **Presumptive Criteria**<br>Select all that apply | |
|---|---|
| ☐You are experiencing homelessness. | ☐Enrolled in the Women, Infants, and Children Nutrition Program (WIC). |
| ☐The Patient is deceased with no estate. | ☐Enrolled in Supplemental Nutrition Assistance Program (SNAP). |
| ☐You are unable to make your own decisions (Mental incapacitation) with no one to act on your behalf. | ☐Enrolled in Illinois Free Lunch and Breakfast Program. |
| ☐You are eligible for Medicaid, but not on the date of service or for non-covered service. | ☐Enrolled in an organized community-based program providing access to medical care that assesses, and documents limited low-income financial status as a criterion for membership |
| ☐Enrolled in Low Income Home Energy Assistance Program (LIHEAP). | ☐Recipient of grant assistance for medical services |

| **Monthly Expenses**<br>Not required if you meet any of the Presumptive Criteria listed above |
|---|
| Housing: |
| Utilities: |
| Food: |
| Transportation: |
| Child Care: |
| Loans: |
| Medical Expenses: |
| Other: |

| **Optional Information**<br>Response/Nonresponse will not have any impact on application outcome |
|---|
| Ethnicity: ☐ White (Non-Hispanic) ☐ Black or African American (Non-Hispanic) ☐ White (Hispanic)<br>☐ Asian ☐ Other (Hispanic) ☐ American Indian or Alaskan Native<br>☐ Native Hawaiian or other Pacific Islander ☐ Multi-racial ☐ Other: _____ *(specify if other)* |
| Sex: ☐ Male ☐ Female ☐ Other: _____ *(specify)* |
| Preferred language: ☐ English ☐ Spanish ☐ Polish ☐ Cantonese ☐ Mandarin ☐ Tagalog<br>☐ German ☐ Korean ☐ Arabic ☐ Urdu ☐ Russian ☐ Italian ☐ Guajarati ☐ Hindi<br>☐ Greek ☐ Other: _____ *(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: |
| Date: |
| Guarantor Signature: _____ |
| Guarantor Name: |
| 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:

**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 any one of the 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

1801 W. Taylor Street, Suite 2B (M/C 668)

Chicago, IL 60612-7232

Telephone: 312-413-7621

Fax: 312-996-1483

Email: getinsured@uic.edu