NorthShore
University HealthSystem

DATE:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help NorthShore University HealthSystem 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 NorthShore University HealthSystem.

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 NorthShore University HealthSystem determine whether you qualify for 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 60 days following the date of discharge or receipt of outpatient care.

The patient/guarantor acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist NorthShore University HealthSystem in determining whether the patient is eligible for financial assistance.

To determine if you qualify for NorthShore Financial Assistance, please return the information checked-off below with this completed packet:

_____ 2 most recent paycheck stubs

_____ Current proof of income from all other sources; such as Unemployment Compensation, Disability Income, SSI, rental property income, pensions, annuities, interest payments, other income etc.

_____ Copies of bank statements for checking, savings, Certificates of Deposit, etc. for the last two months

_____ Confirmation of Support Letter

_____ Other - Income Tax Return for most recent year

_____ Proof of Residency

Please return this completed packet and the requested documentation as soon as possible.

Thank you,

NorthShore University HealthSystem

NorthShore
University HealthSystem

## FINANCIAL DISCLOSURE

| INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION. | | | | | |
|---|---|---|---|---|---|
| **APPLICANT/GUARANTOR INFORMATION** | | | | | |
| Last Name | First | M.I. | Date of Birth | | Social Security Number (Optional) - - |
| Street | Apt. # | City | State | Zip Code | Home Phone |
| Employer Name | | Address | | | Cell Phone |
| City | State | Zip Code | Monthly Gross Income | | Work Phone |
| Email Address | | | Source of Other Income (if applicable) | | Other Income Amount (Monthly) |

| DEPENDENT QUESTIONS | |
|---|---|
| Number of persons in family/household | |
| Number of persons who are dependents of the patient | |
| Ages of the patient's dependents | |

| SPOUSE / (OR PARENT INFORMATION IF MINOR) | | | | | |
|---|---|---|---|---|---|
| Last Name | First | M.I. | Date of Birth | | Social Security Number (Optional) - - |
| Employer Name | | Address | | | Home Phone |
| City | State | Zip Code | Monthly Gross Income | | Cell Phone |
| Source of Other Income (if applicable) | | | Other Income Amount (Monthly) | | Work Phone |

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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 NorthShore University HealthSystem, and I authorize NorthShore University HealthSystem 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 NorthShore University HealthSystem bill.

Applicant Signature: _____

Date:_____

Spouse's Signature (if guarantor): _____

Date:_____

NOTE: If the applicant meets the presumptive eligibility criteria defined in regulations or because of the patient's family income, the applicant is not required to provide monthly expense information or estimated expense figures.

| EXPENSE DESCRIPTION | CREDITOR | MONTHLY PAYMENT DUE | BALANCE DUE |
|---|---|---|---|
| Housing | | | |

| ASSET DISCLOSURE | ESTIMTATED VALUE | OTHER – PLEASE ITEMIZE | ESTIMATED VALUE |
|---|---|---|---|
| Real Estate 1 | | | |
| Real Estate 2 | | | |
| Savings | | | |
| Certificates of Deposit | | | |
| Stocks | | | |
| Mutual Funds | | | |
| Health Savings/Flexible Spending Accounts | | | |

**APPLICANT'S INITIALS:** _____

**SPOUSE'S INITIALS:** _____

NorthShore
University HealthSystem

CONFIRMATION OF SUPPORT LETTER

Dear _____,

The person named above has advised us that you are their sole means of support. To verify this information, please complete this form and return it to us as soon as possible. A return envelope has been provided for your convenience. Thank You.

**The type of support I/WE provide is: (please complete all that apply)**

_____ **Room and board**
**Address of Residence where Room and board is provided:**

_____

_____

_____ **Allowance of $** _____

**Every week** ____ **Every 2 weeks** ____ **Every month** ____

_____ **Other support (please explain)** _____

_____

_____

_____ _____
**Signature of person completing form** **Date**

_____
**Relationship to person named above**

_____
**Signature of Notary Public (if Applicable)**

**Notary Public Stamp (if applicable)**