NorthShore
University HealthSystem

Financial Assistance Application Patient Account Number(s): _____

Important: ***You may be able to receive free or discounted care.***

Completing this application will help NorthShore University HealthSystem (NorthShore) determine if you can receive free or discounted services or other 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. 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 determine whether you qualify for any public programs.

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

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

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.					
APPLICANT INFORMATION					
Email Address					Family Size (Incl. Pt.)
Last Name	First Name	M.I.	Date of Birth		Social Security Number
Street Address	Apt. #	City	State	Zip	Home Phone
Employer Name		Employer Street Address			Cell Phone
Employer City		State	Zip	Gross Monthly Income	Work Phone
Race (Optional)	Ethnicity (Optional)		Gender (Optional)		Preferred Language (Optional)
SPOUSE/GUARANTOR OR PARENT(S) OF MINOR (WHEN APPLICABLE)					
Email Address				Relationship to Patient	Date of Birth
Last Name	First Name			M.I.	Social Security Number
Street Address	Apt. #	City	State	Zip	Home Phone
Employer Name		Employer Street Address			Cell Phone
Employer City		State	Zip	Gross Monthly Income	Work Phone

Presumptive Eligibility:

Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through the benefits provided to their Family are automatically eligible to receive ***free care*** and ***no proof of income will be requested***. We verify eligibility electronically when possible, but may need you to assist us to demonstrate your eligibility.

Check as many as apply:

- ☐ WIC
- ☐ SNAP
- ☐ ILLINOIS FREE LUNCH/BREAKFAST
- ☐ INCARCERATED
- ☐ HOMELESSNESS
- ☐ DECEASED WITH NO ESTATE
- ☐ LIHEAP: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
- ☐ COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAM
- ☐ GRANT ASSISTANCE FOR MEDICAL SERVICES
- ☐ TANF: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
- ☐ PERSONAL BANKRUPTCY (CASE #_____ DISCHARGED DATE_____)
- ☐ AFFILIATION WITH A RELIGIOUS ORDER AND VOW OF POVERTY
- ☐ MEDICAID ELIGIBILITY, BUT NOT ON THE DATE OF SERVICE OR FOR NON-COVERED SERVICE
- ☐ ILLINOIS HOUSING DEVELOPMENT AUTHORITY'S RENTAL HOUSING SUPPORT PROGRAM
- ☐ MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF

**** If you demonstrate Presumptive Eligibility, you do not need to supply any income information. You still need to sign the Applicant Certification on the following page.**

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Income Information:

Please provide the documents requested below (where applicable). Your application may be delayed or denied in the event that any of the required documents are not included.

The following documentation should be provided for the applicant, spouse/partner of the applicant, or if the applicant/patient is a minor, the parent or guardian. If you cannot provide any documentation relating to your income, please complete the letter of support on the last page of this application.

All applicants must provide proof of Illinois residency, which includes any one of the following: valid state-issued identification card, recent residential utility bill, lease agreement, vehicle registration card, voter registration card, other mail addressed to applicant from a government or other credible source, a statement from a family member who resides at the same address and presents verification of residency, or a letter from a homeless shelter, transitional house or other similar facility.
If Employed: • Copy of your prior year tax return • Copies of the two most recent pay stubs • Copies of the two most recent statements for all checking, savings, and credit union accounts
If Self-Employed: • Copy of your prior year tax return • Copies of the two most recent statements for all checking, savings, and credit union accounts
If Unemployed: • Copy of your prior year tax return • Copy of your unemployment award letter that lists your benefit amount • A letter from your previous employer with the termination date • A confirmation of support letter (complete letter on the last page of this application)
If a Full-Time Student: • Proof of college enrollment (including letter from college or university showing your full-time status, or tuition/financial documentation)
If Retired or Disabled: • Copy of your prior year tax return (if applicable) • Copy of your most recent award letter from the Social Security Administration stating the monthly benefit amount • Copies of the two most recent statements for all checking, savings, and credit union accounts
Proof of Other Non-Wage Income: Provide the following information if applicable to your financial situation: • Spousal and/or child support letter • Rental property income • Investment property income • Any other income sources not listed above

Family/Household Information:

Number of persons in family/household	
Number of persons who are dependents of the applicant	
Ages of applicant's dependents	

Other Information:

If you have additional documents that may help NorthShore make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc.)

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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 NorthShore bill. I understand that the information provided may be verified by NorthShore, and I authorize NorthShore 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 bill.

Applicant Signature: _____ Date: _____

Submit completed applications by:	Need Assistance? We can help.
Mail: NorthShore University HealthSystem Patient Financial Services P.O. Box 1006, Suite 330 Skokie, IL 60076-9877 **Fax:** (847) 982-6957 **In Person:** Bring to the hospital financial counselor by visiting a hospital central registration desk	**Call (847) 570-5000** **or meet with a hospital financial counselor by visiting a hospital central registration desk**
For Swedish Hospital: **Mail:** Swedish Hospital Financial Service Center 5145 N. California Ave. Chicago, IL 60625 **Fax:** (773) 878-6838 **In Person:** Bring to the hospital financial counselor by visiting the Financial Service Center	**For Swedish Hospital:** **Call (773) 989-3841** **or meet with a hospital financial counselor by visiting the Financial Service Center**
For Northwest Community Hospital: **Mail:** Northwest Community Hospital Patient Services Center Attn: Financial Counseling 800 W. Central Rd. Arlington Heights, IL 60005 **Fax:** (847) 618-4549 **In Person:** Bring to the hospital financial counselor by visiting the Patient Services Center	**For Northwest Community Hospital:** **Call (847) 618-4542** **or meet with a hospital financial counselor by visiting the Patient Services Center**
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 at 1-877-305-5145 or illinoisattorneygeneral.gov	

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Room and Board Statement/Confirmation of Support Letter

This form is to be completed by the person that is providing room and board and is only to be completed for the applicant if he/she is living with someone other than his/her legal spouse

I currently provide room and board for _____
(Please print applicant's name)

The address where the room and board is provided
_____
_____

I provide a monetary allowance of $_____ per week/month (circle one)

Other support (please explain) _____

Name and address of person providing support (please print)

Name: _____

Address: _____

_____

Phone Number: _____

Signature of Applicant: _____ Date: _____

Signature of Person Providing Support: _____ Date: _____