

Hospital Financial Assistance Application

You may be able to received free or Discounted Care. Completing this application will help Roseland Community Hospital 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 tire hospital.

cial is

Sec	if are Uninsured, a <u>SS Number is not required to qualify for Free Services or Discounted Care</u> . However, a Social rity Number is required for some public programs, including Medicaid. Providing a Social Security Number is equired but will help the hospital determine whether you qualify for any public programs.			
	be complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for or discounted care within 60 days following the date of discharge or receipt of outpatient care.			
I_requ	acknowledged that I had made a good faith effort to provide all information ested in the application to assist the hospital in determining whether I eligible for financial assistance.			
_	bility is based on current Federal Poverty Guidelines, as define in Federal Register. The Family size, total income extenuating situations are considered in the final determination of financial assistance.			
in S ben	Imptive Eligibility: Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria established ction 4500.40 (Source: Amended at 38111Reg 20263), Listed below, whether individually or through the fits provided to their family, are automatically eligible to receive <i>free care</i> and <i>no proof of income</i> will be no red. RCH's staff members will verify Eligibility Electronically.			
	ou demonstrate Presumptive eligibility, you may not need to supply any income information but you still need to sien the cant certification on the following poses**			
	Homelessness			
	Deceased with not estate			
	Mental Incapacitation, with not one to act on patient's behalf.			
	Medicaid eligibility, but with not on date of service or for non-covered service			
	Enrollment in the following assistance programs, low-income eligibility at or below 250% of FPG guidelines.			
	WIC, SNAP, IL free L& B program, LIHEAP.			
	Incarceration			
	Personal Bankruptcy			
☐ IHDA, Rental Housing Support Program				
	Temporary Assistance for Needy Family			
Ac	ount Number: Date of Service: □ Inpatient □ Outpatient			



ROSELAND COMMUNITY HOSPITAL

45 WEST 111™ STREET CHICAGO, IL 60628

<u>Self-Declaration Statement</u> <u>Application for Charity/Uninsured Patient Discounts</u>

I understand that the information, which I submit concerning my annual income and family size, is correct 1 also understand that if the information which I submitted is determined to be false, such determination will result in die denial of providing services as uncompensated services/charity, and that I will be liable for the balance of services provided.

Patient Name:								
	Last	name		Firs	t Name		Initial	
Sex:	Female □	Male □	Date of Birth:					
						MM/DD/YYY		YYYY
Race:	White □	AA 🗆	Latin/Hispa	nic □	Asian 🗆	Native A	American	Other
Address:								
		& Street	City		State	Zip		
Preferred Lang	guage: Eng	glish 🗆 💢	Spanish □	Other []			
Social Security	y Number:							
Home Telepho	one:		(Cell Num	nber			
Email address	:							
Is patient resid	lent of Illinois?)	□ YES	□NO				
The medical c	are services re	ndered were o	lue to a Car A	Accident	or Personal	Injury 🗆 Y	ES □ NO	
Was the patier	nt a victim of C	Crime? □ YES	S □ NO	Fora	minor please	include the	Grantor Infor	mation:
Grantor:								
	Last	name		Firs	t Name		Initial	
Sex:	Female □	Mai	le □			Date of B	irth:	
Social Security	y Number:						MM/DD	YYYY
Γelephone:		(Cell Number:					
Email Address	s:							:
	ntor's Signatur							



Family / Household Information							
Number of persons in the patient's Family							
Number of persons who are depends of the patien	t's						
Ages of the patient's dependents							
Patient's family income & Employment information	Patient's family income & Employment information:						
Is the patient's spouse or partner (parents <i>in case of minor)</i> is currently employed? YES NO Employer information if							
apply: name, address and phone #							
GROSS MONTHLY FAMILY INCOME							
Wages	\$						
Self-Employment	\$						
Unemployment Compensation	\$						
Social Security Income	\$						
Social Security Disability	\$						
Veterans 'Pension	\$						
Veterans' Disability	\$						
Workers 'Compensation	\$						
Retirement income	\$						
TANF	\$						
Child Support, Almonry or other spousal income	\$						
Other income	\$						
TOTAL							

Documentation of Family Income included:

- Paycheck stubs, benefits statements, award letters, court orders, federal tax returns
- Health Insurance. Medicare, part D, Medicare Supplemental, Medicaid, Veterans Benefits
- Asset & estimated asset Value: Checking, Savings, stocks, certificate of deposit, Mutual funds, Automobiles, Real
 property, health savings accounts.



Monthly Family Expenses

1.	Housing:
	Utilities:
	Food:
4.	Transportation:
5.	Child Care:
	Loans:
	Medical Care:
0	Others:

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 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 or Applicant' Signature	Date	
Hospital Representative Name	Date of Determination:	