NorthShore | Edward-Elmhurst HEALTH

Financial Assistance Application Patient Account Number(s): _____

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

Completing this application will help NorthShore – Edward Elmhurst Health (NS-EEH) 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 NS-EEH determine whether you qualify for any public programs.

Please complete this form as soon as possible after the date of service in order for NS-EEH to determine your eligibility for financial assistance. NS-EEH 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 NS-EEH 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 and/or Form W-2, 1099, etc. • 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 and/or Form W-2, 1099, etc. • Copies of the two most recent statements for all checking, savings, and credit union accounts
If Unemployed: • Copy of your prior year tax return and/or Form W-2, 1099, etc. • 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 and/or Form W-2, 1099, etc. (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 NS-EEHNS-EEH 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 NS-EEH bill. I understand that the information provided may be verified by NS-EEH, and I authorize NS-EEH 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 NS-EEH bill.

Applicant Signature: _____ Date: _____

Where to submit completed applications:

Hospital:	**Evanston Hospital** **Glenbrook Hospital** **Skokie Hospital** **Highland Park Hospital**	**Swedish Hospital**	**Northwest Community Hospital**	**Edward Hospital** **Elmhurst Hospital** **Linden Oaks**
Mail:	NorthShore University HealthSystem Patient Financial Services P.O. Box 1006, Suite 330 Skokie, IL 60076-9877	Swedish Hospital Financial Service Center 5145 N. California Ave, Chicago, IL 60625	Northwest Community Hospital Patient Services Center Attn: Financial Counseling 800 W. Central Rd. Arlington Heights, IL 60005	Edward-Elmhurst Health Financial Assistance Dept 4201 Winfield Rd Warrenville, IL 60555
Fax, Email, or Patient Portal:	(847) 982-6957 or upload to NorthShore Connect	(773) 878-6838 or upload to NorthShore Connect	(847) 618-4549 or upload to NCH MyChart	(331) 221-2704 or email to financialassistance@eehealth.org
Phone:	(847) 570-5000	(773) 989-3841	(847) 618-4542	(866) 756-8348
In Person:	Submit completed applications and supporting documentation to a hospital financial counselor by visiting the hospital that you are applying for assistance.			

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/or financial support 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 (select all that apply)

☐ Financial Support
☐ Room and Board

for _____ for the past _____

I am not liable for medical expenses incurred by the above mentioned person

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: _____

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Self-Employment Verification

This self-employment income is for the most current period of _____ through _____.

Because you are self-employed, you are required to provide accurate and complete records of your employment income and employment expenses in order to process your financial assistance application. Using the chart below, you must provide all money you take in and its source. You must also list any expenses you had in producing your income during the reporting period. Expenses of producing income include but are not limited to things like inventory, materials, services, transportation, employee salaries, and loan payments.

Business Income Source	Date Received	Gross Income	Business Expense/Item Purchased/Paid to Whom	Amount

I hereby state that the information provided in this document is true and accurate to the best of my knowledge.

Signature of Applicant: _____ Date: _____

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Employer Wage Verification

This statement is to confirm that _____has been employed at
(name of employee)

_____ since _____.
(name of employer) (date of hire)

_____ receives a gross income (before deductions
(name of employee)

for taxes, social security, insurance, etc.) of $_____.

The frequency of payment is:

☐Weekly
☐Every two weeks
☐Twice a month
☐Monthly
☐Annually

_____ / _____ Date:_____
Signature of Employer Title

_____ _____
Address State Zip Code Telephone Number