



## 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 <small>(not required if you are uninsured)</small> :	
Was the patient an Illinois resident when care was rendered?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the patient involved in an accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the patient a victim of an alleged crime?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the following information:	
Policy Holder:	Policy Holder:
Insurer:	Insurer:
Policy Number:	Policy Number:

<b>Guarantor Information (if different from patient)</b>			
Relationship	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____ (specify)
Name:			
Address:			
City:	State:	Zip Code:	
Home Phone #:	Cell Phone #:		

<b>Family/Household Information</b>
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?

<b>Employment/Income Information</b>		
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your spouse currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer Name:		
Employer Address:		
Employer City:	State:	Zip Code:
Employer Phone #:		
Gross Monthly Family Income: (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)		

<b>Optional Information</b>
Response/Nonresponse will not have any impact on application outcome
Ethnicity: <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Black or African American (Non-Hispanic) <input type="checkbox"/> White (Hispanic) <input type="checkbox"/> Asian <input type="checkbox"/> Other (Hispanic) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other: _____ (specify if other)
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____ (specify)
Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Cantonese <input type="checkbox"/> Mandarin <input type="checkbox"/> Tagalog <input type="checkbox"/> German <input type="checkbox"/> Korean <input type="checkbox"/> Arabic <input type="checkbox"/> Urdu <input type="checkbox"/> Russian <input type="checkbox"/> Italian <input type="checkbox"/> Gujarati <input type="checkbox"/> Hindi <input type="checkbox"/> Greek <input type="checkbox"/> 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:

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For Internal Use	Received on:	Received by:	Completed:	Last Update: 01/21/22
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## **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 all 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](mailto:getinsured@uic.edu)