

Date: _____



LOYOLA UNIVERSITY MEDICAL CENTER Application for Financial Assistance

To help us determine if you are qualified to receive financial assistance, please complete and return the enclosed application along with copies of the documents as listed below.

Patient Name: _____ Date of Birth: _____

Annual Household Income: _____

Medical Record or Hospital Account # _____ Marital Status: _____

Number of persons who are legal dependents whether or not they reside in the home: _____

Patient or Guarantor Information:

Name: _____ Relationship to Patient: _____

Address: _____ Telephone: (____) _____

_____ Cell Phone (____) _____

Employer Name: _____ Occupation: _____
____ Full Time ____ Part Time

Primary or Legal Residence (Guarantor)

Address: _____

Monthly Expenses:

Living Expenses: \$ _____ Mortgage/Rent/Food/Utilities, etc. __ Own __ Rent __ Other

Installment Payments: \$ _____ Auto/Credit/Loans, etc.

Other Expenses: \$ _____ Insurance premiums/childcare, etc.

Out of pocket expenses for medical care in the past 12 months: \$ _____

Checking/Saving Accounts(s)

Checking Account Balance: \$ _____ Savings: \$ _____

Other monetary Assets Cash Value: \$ _____ 401K/Stocks/CDs/Life Ins.,etc.

Complete the following questions:

Have you applied for any government sponsored medical program (even if denied) within the past 6 months? YES/NO

Are any of the services related to an accident? YES/NO

Are you the beneficiary in any trust fund/inheritance? YES/NO

Are you purchasing or own any real estate property other than your primary residence? YES/NO

If you have answered YES to any of these questions, please explain:

The supporting documents listed are required for household members.

- * **Three most recent paycheck stubs or other proof of income.**
- * **Most recent federal income tax return, schedules and W-2's for all household members**
- * **Social Security award letter (income or disability).**
- * **Most recent Checking & savings account statement (online banking statements will not be accepted; the statement must include all pages and deposits must be explained.)**
- * **Drivers license or other state-issued ID.**
- * **Unemployment Compensation Benefit Award letter.**
- * **Room & Board, Rent, Lease or Mortgage statement.**

I understand that the determination of eligibility will affect only the portion I owe as of the date of receipt of the completed application and the determination of eligibility is at the sole discretion of Loyola University Medical Center.

Determination of this application will be delayed or denied if all information requested is not provided at the time of the application.

By signing, you agree that the following information provided in this application is true and correct to the best of your knowledge. You understand that Loyola University Medical Center will retain this application, including all documentation provided, whether or not it is approved. Furthermore, you authorize Loyola University Medical Center to check your credit history and make all inquiries deemed necessary to complete this application process.

Patient Signature: _____ Date: _____

**Please send the application and all supporting documents within thirty (30) business days.
INCOMPLETE APPLICATIONS MAY NOT BE PROCESSED.**

**Send to: Loyola University Medical Center, Business Service Administration
Mulcahy Building-First Floor Rm 1538-B
2160 South First Avenue, Maywood, IL 60153**

If you have any other questions or need help completing the application, please call us at the number below.

Patient Financial Services Department Ph: 800-424-4840