LOYOLA MEDICINE

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Application for Financial Assistance

Thank you for choosing Loyola Medicine for your healthcare services. To help us determine if you are qualified to receive financial assistance, please complete and return along with copies of the documents listed on the application.

- **Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:** Completing this application will help Loyola Medicine determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit the 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 and submit it to the hospital in person, by mail, electronic mail, or by fax to apply for free or discounted care within two-hundred forty **(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.

- **Assets:** Loyola Medicine does not consider assets when determining eligibility for hospital financial assistance. You are not required to disclose assets as part of this application.

- **Note: Presumptive Eligibility Notice**
  Patients may be determined eligible for financial assistance without completing this application using presumptive eligibility methods permitted under Illinois law.

Income documentation for an uninsured patient is limited to any one (1) of the following

(A) ☐ A copy of the most recent tax return with schedules

(B) ☐ A copy of the most recent W-2 form and 1099 forms

(C) ☐ Copies of the 2 most recent pay stubs

(D) ☐ Written income verification from an employer if paid in cash

(E) ☐ One other reasonable form of third-party income verification deemed acceptable to the hospital

Provide the following, If applicable]

☐ [Recent W2 for Seasonal Income] ☐ [Unemployment/Social Security Benefit] ☐[Child Support Income/Alimony]

☐ [No Income – Complete Letter of Financial Support portion of the application]

Patient Information			
[Patient Name]		[Date of Birth]	
[Social Security/EIN Number (optional)]	[Mobile Phone]	[Other Phone]	
[Mailing Address]	[City]	[State]	[ZIP code]
[Email Address]	[Of what state are you a resident?]		
[Marital status (optional)] □[Single] □[Married] □[Divorced] □[Other] _____			
[Do you file a Federal Tax Return?] □ [Yes] □ [No] [If no, why?]	[Can you be claimed as dependent on someone else's tax return?] □ [Yes] □ [No]		
[Did you or your dependents have health insurance coverage at the time of service?] □[Yes] □[No] [(Provide Insurance card copy)]			

[Household Members, including yourself based on your recent Tax Returns]	[Date of Birth]	[Relationship to Patient]	[Claimed on Tax Return (Yes/No)]

[Monthly Expenses: List monthly expenses for the household]

☐ Rent or mortgage	☐ Utilities
☐ Food	☐ Child support/Alimony paid
☐ Transportation/Car Payment	☐ Medical Expenses/Loans
☐ Childcare/Dependent care	☐ Other

Total Monthly Expense: _____

[Income Verification for all household members]

[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]	[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]
[Social Security/Disability]			[Worker's Compensation]		
[Pension]			[Unemployment]		
[Self-Employment]			[Child Support/Alimony]		
[Public Assistance]			[Rental Land Income]		
[Other]					

[Letter of Financial Support - Should only be completed by the person providing support]

☐ [I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]

☐ [By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____ (Phone Number)]

[Name of person providing support]	**[Relationship to Patient]**
[Signature of person providing support]	**[Date]**

[VERIFICATION OF INCOME AND IDENTIFICATION]

[I certify that the information listed in this application is true and complete 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. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses]

[Signature of Patient]: _____
[Date]: _____

[Or Signature of Legal Guardian (If Applicable)]: _____
[Date]: _____

[Relationship to Patient]: _____
[Date]: _____

[Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - https://mychart.trinity-health.org/MyChart If you have any questions, please contact our Customer Service Center at 866-404-9382 Monday through Friday 9 a.m. -5 p.m. ET.]

Concerns or complaints with the financial assistance application process or uninsured discount may be reported to the Healthcare Bureau of the Illinois Attorney General 1-877-305-5145/ https: illinoisattorneygeneral.gov/consumers/hcform.pdf