LOYOLA MEDICINE

Date: _____

LOYOLA UNIVERSITY MEDICAL CENTER
Application for Financial Assistance

Thank you for choosing Loyola University Medical Center 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 as listed on the application.

- **Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:** Completing this application will help Loyola University Medical Center 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 of discounted care within 60 days following 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.
- **Note:** If the patient meets Loyola University Medical Center's presumptive eligibility criteria as described in its Presumptive Eligibility policy or is otherwise presumptively eligible for financial assistance by virtue of the patient's family income, then the patient shall not be required to complete the MONTHLY EXPENSES section of this application.
- The determination of eligibility will affect only the portion you 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.

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Patient SS# (not required if patient is uninsured): _____

Phone #: _____ Email Address: _____

Address: _____

Were you involved in an alleged crime or alleged accident? YES/NO

Were you an Illinois resident at the time he/she received services from Loyola? YES/NO

Note: If your spouse/partner is the guarantor, or if the patient is a minor and the minor parent or guardian is the guarantor, then include the name, address, and telephone number for the guarantor below.

Name of Guarantor: _____ Guarantor Phone #: _____

Guarantor Address: _____

FAMILY/HOUSEHOLD INFORMATION:

Number of persons in the patient's household: _____

Number of persons who are dependents of the patient: _____ Ages of patient's dependents: _____

FAMILY INCOME AND EMPLOYMENT INFORMATION:

Is patient or patient's spouse, partner, parents/guardians (for minors) currently employed? YES/NO

If Yes, provide the following information for each employer (Name, Address, Phone #). Attach additional sheets as necessary.

Employer Name: _____ Employer Name: _____

Employer Phone #: _____ Employer Phone #: _____

Employer Address: _____ Employer Address: _____

If divorced or separated, is your spouse/partner financially responsible for the patient's medical care per a dissolution/separation agreement? YES/NO

If Yes, please explain: _____

_____

_____

Provide patient's gross monthly income from the any of the following sources. Include cases where a spouse, partner, or parent/guardian is guarantor for the patient:

Wages: _____

Self-employment: _____

Unemployment compensation: _____

Social Security: _____

Social Security disability: _____

Veteran's pension: _____

Veteran's disability: _____

Private disability: _____

Worker's compensation: _____

Temporary assistance for needy families (TANF): _____

Retirement income: _____

Child support, alimony, or other spousal support: _____

Other income: _____

TOTAL GROSS MONTHLY INCOME: $_____

INSURANCE/BENEFIT INFORMATION:

Please list any private health insurance or government sponsored insurance (such as Medicare, Medicaid or Veterans Administration):

_____

_____

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

If Yes, list the program(s): _____

Have you left an employment within the last 30 day? YES/NO

If Yes, do you qualify for Cobra benefits? YES/NO

If Yes:

Name of Employer: _____

Name of health insurance: _____

ASSET AND ESTIMATED ASSET VALUE INFORMATION:

Please check any that apply and list the present value for each asset:

- ☐ Real property, including residence/ home — Present Value (all real estate): _____
- ☐ Automobile(s)/ other vehicles(s) — Present Value (all vehicles): _____
- ☐ Checking and Savings — Present Value (all accounts): _____
- ☐ Stocks — Present Value: _____
- ☐ Certificates of deposit — Present Value: _____
- ☐ Mutual Funds — Present Value: _____
- ☐ Health savings/Flexible spending account — Present Value: _____

TOTAL VALUE: **$**_____

LOYOLA UNIVERSITY MEDICAL CENTER MAY REQUIRE YOU TO SUBMIT DOCUMENTATION VERIFYING THE VALUE OF YOUR ASSETS. ACCEPTABLE DOCUMENTATION MAY INCLUDE STATEMENTS FROM FINANCIAL INSTITUTIONS OR SIMILAR THIRD PARTIES VERIFYING ASSET VALUATION.

ESTIMATED MONTHLY EXPENSES:

Please indicate estimated monthly expenses for the following:

Housing _____

Utilities _____

Food _____

Transportation _____

Child care _____

Loans _____

Medical expenses _____

Other expenses _____

TOTAL MONTHLY EXPENSE: $ _____

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 assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient/Guarantor Signature: _____

Date: _____

SUPPORTING DOCUMENTATION:

In order to verify family income, please provide any **one (1)** of the following for the patient/guarantor and for each member of the patient/guarantor's household:

- ☐ A copy of the most recent income tax return with schedules A copy of the most recent W-2 form and 1099 forms
- ☐ If paid in cash, a letter from an employer stating amount paid weekly
- ☐ Social Security award letter (income or disability) or unemployment compensation award letter
- ☐ Copies of the **two (2)** most recent pay stubs **only if you are unable to produce one of the above documents**.

In order to verify residency for the patient, please provide any **one (1)** of the following:

- ☐ Valid state-issued identification card (such as a driver's license) Rent receipt or lease
- ☐ Recent residential utility bill Vehicle registration card Voter registration card
- ☐ Mail addressed to the patient at an Illinois address from a government or other credible source
- ☐ A statement from a family member of the patient who resides at the same address as the patient and presents valid verification of the patient's residency
- ☐ A letter from a homeless shelter, transitional house or other similar facility verifying that the patient resides at the facility

Please send the application and all supporting document(s) required within sixty (60) business days.

*****INCOMPLETE APPLICATIONS MAY NOT BE PROCESSED.*****

Send to: Loyola University Health System,
Patient Financial Services Department
Two Westbrook Corporate Center, 7th Floor
Westchester, Illinois 60154

Fax #: 708-216-2237 Email address: LOY-FinancialAssist@lumc.edu

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