Financial Assistance Application

Patient Name: _____

MRN: _____

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Northwestern Memorial HealthCare (NMHC) 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 the hospital determine whether you qualify for any public programs. Please complete this form and submit it 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 NMHC in determining whether the patient is eligible for financial assistance.

IF YOU ARE UNINSURED AND MEET SPECIFIC PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.

- ☐ Homelessness
- ☐ Deceased with no estate
- ☐ Mental incapacitation with no one to act on patient's behalf
- ☐ Medicaid eligibility, but not date of service

Enrollment in assistance programs for low-income individuals:

- ☐ Women, Infants and Children Nutrition Program (WIC)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Illinois Free Lunch and Breakfast Program (LIHEAP)

APPLICANT			
Applicant Name	Social Security #		Date of Birth
Home Address	City	State	Zip
Home Phone Number	Cell Phone Number	Email Address	
Preferred Method of Contact ☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone ☐ I am homeless			Annual Household Income
Applicant's Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow			# of Individuals in your Household *(as reported on your taxes)*
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed – Last date worked: _____			
Employer Name			Phone Number
Employer Address	City	State	Zip
Name of Health Insurance plan offered by employer (including COBRA)			☐ Health Insurance not provided

SPOUSE/PARTNER/PARENT/GUARANTOR (when applicable)			
Relationship ☐ Spouse ☐ Partner ☐ Parent ☐ Guarantor ☐ Other: _____			
Name	Social Security #		Date of Birth
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed – Last date worked: _____			
Employer Name			Phone Number
Employer Address	City	State	Zip
Name of Health Insurance plan offered by employer (including COBRA)			☐ Health Insurance not provided

INSURANCE COVERAGE

1. Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefits, Medicaid, and Medicare? ☐ Yes ☐ No
   a. If yes, please provide the following information:

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

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QUESTIONNAIRE				
1.	Were you an Illinois resident when you received your care?		□ Yes	□ No
2.	Are you a foreign national residing in Illinois on a U.S. Visa?		□ Yes	□ No
	a. If yes, what type of Visa? _____			
3.	Are you seeking financial assistance for care received in our emergency room?		□ Yes	□ No
4.	If you are divorced or separated, is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement?	□ N/A	□ Yes	□ No
5.	Is the treatment provided related to any of the following? ☐ Accident ☐ Crime ☐ Workplace Injury ☐ Other: _____			
6.	Have you hired an attorney or are you pursuing a claim for your injury or illness?		□ Yes	□ No
	a. If yes, please provide: Attorney Name _____ Attorney Phone Number _____			
7.	Have you already applied for Medicaid? *(we may require that you do so)*	□ Yes – Awaiting Approval	□ Yes – Not Eligible	□ No
	a. If no, please check all of the below that apply:			
	☐ You are 19 years or younger ☐ You are taking medication to control diabetes, high blood pressure, or seizures	☐ You are 65 years or older ☐ You are disabled as determined by the determined by the Social Security Administration	☐ You are blind ☐ You are pregnant ☐ You have children under the age of 19 living with you	

ASSETS			
1.	**Property.** Please provide information regarding any property *(buildings and/or land)* that you own **other than your primary residence**.		
	a. What is the value of all buildings and land minus the amount owed on the property?	$ _____	□ N/A
	i. Is this property used as income? □ Yes □ No		
	b. What is the value of the land (without buildings) minus the amount owed on the property?	$ _____	□ N/A
	i. Is this property used as income? □ Yes □ No		
2.	**Bank Accounts/Investments.** Please list the total current balance for each of the following.		
	a. Checking/Savings/Credit Union Accounts:	$ _____	□ N/A
	b. Other Investments *(bonds, stocks, etc. **excluding** IRA and/or retirement accounts)*:	$ _____	□ N/A

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 NMHC, and I authorize NMHC 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, or if the application otherwise contains a material error or omission, I will be ineligible for financial assistance, and any financial assistance granted to me may be reversed and I will be responsible for the payment of the bill.

Applicant Signature _____

Spouse/Partner/Parent/Guarantor Signature (when applicable) _____

Date _____

Date _____

Please return completed application and supporting documents to:

Northwestern Memorial HealthCare
Attention: Financial Counseling
675 North Saint Clair, 2-110
Chicago, IL 60611
312.926.6906 or 800.423.0523 telephone
312.694.0447 fax
finapps@nm.org

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Financial Assistance Required Supporting Documents

Please provide the documents requested below. Your application will be delayed or denied in the event that any of the required documents are not included. If you cannot provide document, please provide a letter of explanation.

Primary Dcouments:

- Tax Documents: Provide your most recent federal tax return and W-2 or IRS Form 4506-T: Request for Transcript of Tax Return.
- Valid Government-Issued Photo ID:
  - ☐ Driver's license, passport, etc.
- Proof of Illinois Residency: Provide at least one of the following documents.
  - ☐ Valid state-issued photo ID or driver's license
  - ☐ Recent utility bill with an Illinois address
  - ☐ IL Voter Registration card
  - ☐ Current mail addressed to applicant from a government or other credible source
  - ☐ Letter from homeless shelter
- Proof of Income: Provide all applicable documents listed below.
  - ☐ Copies of your two most recent unemployment checks or stubs
  - ☐ Copies of your two most recent employer checks or stubs
  - ☐ Copies of your two most recent Social Security checks or stubs
- Proof of Assets: Provide your two most recent statements for all checking, savings, and credit union accounts.
- Completed and signed application

Supplemental/Other Documents:

- Proof of Non-Wage Income: Provide the following applicable documents, only if you have not submitted a tax return for the previous calendar year or if any of the following income sources will vary between this calendar year and the previous calendar year.
  - ☐ Statement of alimony income
  - ☐ Statement of business income
  - ☐ Statement of retirement or pension income
- If Married or in a Civil Union: Provide the following applicable documents regarding your spouse/partner
  - ☐ Proof of income and non-wage income (as described above)
  - ☐ Federal tax return and W-2 or IRS Form 4506-T: Request for Transcript of Tax Return
  - ☐ Most recent statement for all checking, savings and credit union accounts
- Supplemental/Other (if applicable):
  - ☐ If a foreign national, copy of your passport and United States Visa
  - ☐ Health insurance card (please copy front and back)
  - ☐ Medicaid approval/denial letter
  - ☐ Letter of support (i.e. if your living expenses are being paid by another party)