



5601 S. County Line Road
Hinsdale, IL 60521
(630) 286-4516

3435 W. Van Buren St.
Chicago, IL 60624
(773) 826-6300

Application for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help RML Specialty Hospital (aka RML Chicago) 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 60 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.

I. PATIENT INFORMATION

Patient Name:

First Middle Last

Address City State Zip Code

Date of Birth: _____

Currently an Illinois Resident? Yes / No

Was your hospitalization at RML the result of an alleged accident? Yes / No

Social Security Number: _____ (Not required if you are Uninsured)

Telephone Number: _____

Cell #: _____

Email Address: _____

PATIENT GUARANTOR INFORMATION:

If the spouse or partner is a guarantor for the patient or in which a parent or guardian is a guarantor for a minor, provide the following information:

Guarantor Name: _____

Guarantor
Address: _____

Guarantor Telephone Number: _____

II. FAMILY / HOUSEHOLD INFORMATION

Number of persons in the patient's family/household: _____

Number of persons who are dependents of the patient: _____

Ages of patient's dependents: _____

III. PATIENT'S FAMILY INCOME AND EMPLOYMENT INFORMATION

Is the patient, patient's spouse or partner currently employed? Yes / No

If the patient is a minor, are either the parents or guardian of patient currently employed? Yes / No

If yes to either question above please complete the following employer information.

Circle One: Patient Spouse Partner Parent Guardian

Employer Name: _____

Employer Address: _____

Employer Telephone Number: _____

Circle One: Patient Spouse Partner Parent Guardian

Employer Name: _____

Employer Address: _____

Employer Telephone Number: _____

Circle One: Patient Spouse Partner Parent Guardian

Employer Name: _____

Employer Address: _____

Employer Telephone Number: _____

If patient is divorced or separated or a party to a dissolution proceeding, is the former spouse or partner financially responsible for a patient's medical care per the dissolution of separation agreement? Yes / No

GROSS MONTHLY FAMILY INCOME

	<u>Patient</u>	<u>Partner or Spouse</u>	<u>Parent or Guardian</u>
Wages	_____	_____	_____
Self-employment	_____	_____	_____
Unemployment Compensation	_____	_____	_____
Social Security	_____	_____	_____
Pension / Retirement Income	_____	_____	_____
Disability (all types)	_____	_____	_____
Worker's Compensation	_____	_____	_____
Temporary Assist. – Needy Family	_____	_____	_____
Child Support & Alimony	_____	_____	_____
Other Income Sources	_____	_____	_____
Total Monthly Income Sources	=====	=====	=====

Provide documentation of all sources of family income. Examples of such documentation include 2 most recent paycheck stubs, benefit statements, award letters, court orders, federal tax returns or other documentation to substantiate your income sources.

IV. INSURANCE/BENEFIT INFORMATION

Please indicate with an X if you have the following health insurance:

Medicare: _____
Medicaid _____
Medicare Supplement: _____
Private/Commercial Insurance: _____
Veteran's Benefits: _____

V. ASSET AND ESTIMATED ASSET INFORMATION

	<u>Amount</u>
Checking Account	_____
Savings Account	_____
Stocks	_____
Certificates of Deposit	_____
Mutual Funds	_____
Health Savings Account	_____
Flexible Spending Account	_____
Real Property	_____
Automobile(s)	_____
Total Assets	_____

VI. MONTHLY EXPENSES AND ESTIMATED EXPENSES

	<u>Amount</u>
Housing	_____
Utilities	_____
Food	_____
Transportation	_____
Child Care	_____
Loans	_____
Medical Expenses	_____
Other Expenses	_____
Total Monthly Expenses	=====

Note: If patient meets presumptive eligibility criteria for free care or is otherwise presumptively eligible by virtue of patient's family income, the patient is not required to complete this section VI – Monthly Expenses and Estimated Expenses.

VII. 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 (RML Specialty Hospital, aka RML Chicago) 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, and financial assistance granted to me may be reversed, and I will be responsible for payment of the hospital bill.

Patient or Applicant Signature

Date