



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.

Contact Information for Help

Should you have any questions or concerns regarding this application or eligibility for financial assistance, please refer to the below contact information.

Hinsdale

Admitting Department
5601 S. County Line Rd.
Hinsdale, IL 60521
Phone #: 630-286-4516
Fax #: 773-826-2851

Chicago

Admitting department (by appointment)
3435 W Van Buren Street
Chicago, IL 60624
Phone # 630 286-4516
Fax #: 773 826-2851

Website: <https://www.rmlspecialtyhospital.org/discharge-planners/financial-information/#financial>

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the

Illinois Attorney General. You can contact the Illinois Attorney General's office at the below contact information.

Phone # 1-877-305-5145

Website <https://illinoisattorneygeneral.gov/consumers/hcform.pdf>

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: _____

The following information (Race, Ethnicity, Sex & Language) is optional:

Race _____

Caucasian

Hispanic

African American

American Indian

Asian

Some Other Race _____

Sex

Male

Female

Ethnicity _____ Preferred Language

Hispanic _____ English

Latino _____ Spanish

Spanish _____ Other Language _____

Cuban

Some Other Ethnicity PATIENT GUARANT OR 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	=====

