

Date: \_\_\_\_\_.

Mr(s) \_\_\_\_\_.

The following documentation is required in order to apply for Financial Assistance with Saint Anthony Hospital. Please return all documents that apply to you to the address below within the next 30 days so that we may determine your eligibility.

- **Identification with current proof of state of Illinois residency.**  
Driver's license, State ID, Lease agreement, mortgage statement or Utility bill.
- **The balance is not a co-pay or deductible fee.**
- **Proof of income from all working persons in the household:**  
A complete copy of the previous year's income tax returns with W2.  
Unemployment benefit checks (If recently unemployed)  
Last 3 check stubs (*patient and spouse if applicable*).  
Social Security benefits letter (if applicable)
- **Letter of support (preferably notarized) if not employed.**
- **Proof of dependents.** (if not listed on tax forms)  
Birth Certificate, Social Security card or Identification.
- **Additional documentation may be required upon application review.**

If you have any questions please feel free to contact us at  
(773) 484-4800 from 7:00 AM to 5:00 PM Monday thru Friday.

**PLEASE MAIL ALL THE DOCUMENTATION TO:  
SAINT ANTHONY HOSPITAL  
P.O. BOX 85082  
CHICAGO, ILLINOIS 60689-5082  
ATTN: CUSTOMER SERVICE REP.  
SUBMIT VIA FAX TO (773) 484-4806**

**PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL & SAH EMPLOYED PHYSICIANS SERVICES.**

**Saint Anthony Hospital**  
**Financial Assistance Application**

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Saint Anthony Hospital 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 30 days. **You will receive a final determination letter via mail within 30 days upon receipt of all required documents.**

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.

*Internal Use Only:*

Application Date: \_\_\_\_\_ MRN: \_\_\_\_\_ Account Balance: \$ \_\_\_\_\_

Visit ID Numbers: \_\_\_\_\_

Approved %: \_\_\_\_\_ Fam/Unit: \_\_\_\_\_ \$ \_\_\_\_\_ Denied: \_\_\_\_\_

Reason: \_\_\_\_\_

**Patient Information:**

Patient Name: \_\_\_\_\_ Phone Number: Home: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Phone Number: Cell: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient an Illinois resident at time of service? (circle one) YES NO

Patient involved in an alleged accident? (circle one) YES NO

Patient victim of an alleged crime? (circle one) YES NO

Patient Social Security Number (not required if uninsured): \_\_\_\_\_

Patient email address (optional): \_\_\_\_\_

***If applicable: Guarantor Information (if patient is a minor or spouse/partner is responsible for patient):***

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

Guarantor telephone or cell phone number: \_\_\_\_\_

**Family Household Information:**

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

Number of persons who are dependent of the patient: \_\_\_\_\_

List the ages of the dependents in the household:

Dependents	Age
Dependent 1	
Dependent 2	
Dependent 3	
Dependent 4	
Dependent 5	
Dependent 6	

**Patient's Family Income and Employment Information:**

Patient – are you employed? (circle one) YES NO

*If yes, please complete the following:*

Name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Telephone number of employer: \_\_\_\_\_

Spouse of patient – are you employed? (circle one) YES NO

*If yes, please complete the following:*

Name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Telephone number of employer: \_\_\_\_\_

If the patient is a minor, is the parent or guardian of the minor employed? (circle one) YES NO

*If yes, please complete the following:*

Name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Telephone number of employer: \_\_\_\_\_

If the patient is a minor, is the other parent or guardian of the minor employed? (circle one) YES NO

*If yes, please complete the following:*

Name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Telephone number of employer: \_\_\_\_\_

Marital status of the patient (please circle one):

Single

Married

Widowed

Separated\*

Divorced\*

\*If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order? (circle one) YES NO

**Gross monthly family income:**

\$	Total household employment income (including self employed)
\$	Unemployment compensation
\$	Social Security
\$	Social Security Disability
\$	Veterans' pension
\$	Veterans' disability
\$	Private disability
\$	Workers' Compensation
\$	Temporary Assistance for Needy Families
\$	Retirement Income
\$	Child Support, alimony or other spousal support
\$	Other Income
\$	Total gross monthly family income

Please provide documentation of the following:

- Paycheck stubs (last 4)**
- Benefit statements**
- Award letters**
- Court orders**
- Federal tax returns**
- Other documentation in support of income**

Are you enrolled in any of the following? (circle all that apply)

- Women, Infants and Children Nutrition Program (WIC)*
- Supplemental Nutrition Assistance Program (SNAP)*
- Illinois Free Lunch and Breakfast Program*
- Low Income Home Energy Assistance Program (LIHEAP)*
- Any community-based program that provides access to medical care based on low-income financial status*
- Receipt of grant assistance for medical services*
- Temporary Assistance for Needy Families (TANF)*
- IHDA's Rental Housing Support Program*

**Insurance/Benefit Information:**

Does the patient have medical insurance? (circle one)    YES    NO    Type of coverage (please circle one):

Health                      Medicare                      Medicare Part D                      Medicare Supplement                      Medicaid                      Veterans'

Insured Member Name: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

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

Patient or applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a patient meets the presumptive eligibility criteria of Saint Anthony Hospital or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

**PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL & SAH EMPLOYED PHYSICIAN SERVICES.**

**LETTER OF SUPPORT**

Date \_\_\_\_\_

Name (s) \_\_\_\_\_  
*(Person/s that provides room & board)*

Address \_\_\_\_\_

Phone # (s) \_\_\_\_\_

I/We provide room & board to : \_\_\_\_\_  
*(Patient's Name)*

since (date) \_\_\_\_\_ to present.

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

<p><b>SUBSCRIBED TO AND SWORN before me</b></p> <p>this _____ day of _____, 20____</p> <p>Notary Public</p>
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