Saint Joseph Hospital

77 N. Airlite Street, Elgin, IL 60123

We are sending you this letter along with the attached financial assistance application in response to your request. If you did not submit a request, please disregard this notice.

Dear Patient/Applicant,

Saint Joseph Hospital is driven by compassion and dedicated to providing personalized care for all, especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for your healthcare needs.

Please complete the application, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income:

- Two (2) most recent paystubs from employer
- Most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent/Guardian's most recent yearly tax return (if applicant is a dependent listed on their tax form and under the age 25)
- Other income validation documents
- Bank statements from last 3 months
- Receipt of unemployment benefits

If you receive assistance from, or live in a home with, family or friends, please ask them to complete the attached "Letter of Support" form. This will not make them responsible for your medical bills. It simply helps us understand how you are able to meet your living expenses. If you do not receive assistance from family or friends, please remember that your completed application and proof of income must be submitted for us to consider your request. Unfortunately, we cannot process incomplete applications.

Please keep in mind that email communications over the internet are not fully secure. While unlikely, there is a possibility that information you include in an email could be intercepted and read by someone other than the intended recipient. Because your application contains sensitive information, including your Social Security number, we want to protect your privacy and ensure your information remains secure. For this reason, we strongly encourage you not to send the application by email.

If you have any questions about the application process, please contact Saint Joseph Hospital Patient Financial Services at 773-990-3289.

Sincerely,
Saint Joseph Hospital Patient Financial Services

Saint Joseph Hospital

77 N. Airlite Street, Elgin, IL 60123

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Saint Joseph 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 Saint Joseph Hospital determine whether you qualify for any public programs. For any application questions marked "optional," your response (or non-response) will not have any impact on the outcome of the application.

Please complete this application and submit it to Saint Joseph Hospital by mail, by electronic mail (email), or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your application for up to 240 days following the first billing statement for your care. By submitting this application, you acknowledge that you have made a good faith effort to provide all information request in the application to assist Saint Joseph Hospital in determining whether the patient is eligible for financial assistance. If you have any questions on the application process, you may contact Saint Joseph Hospital Patient Financial Services with questions or concerns at 773-990-3289.

Mail this application to: Saint Joseph Hospital c/o Patient Financial Services-HBRC 3628 E Imperial Hwy, Suite 104 Lynwood, CA 90262	**Email this application to:** FinancialAssistance@primehealthcare.com
	Fax this application to: 310-900-8857

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. The Health Care Bureau's toll-free hotline is 877-305-5145 (TTY 800-964-3013).

Patient Information

Date _____

Account number _____

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Gender Identity ***(Optional)*** Do you think of yourself as:

☐ Male ☐ Female

☐ Transgender man/trans man/female-to-male (FTM)

☐ Transgender woman/trans woman/male-to-female (MTF)

☐ Genderqueer/gender nonconforming neither exclusively male nor female

☐ Additional gender category (or other)

Gender Identity ***(Optional)***
What sex was originally listed on your birth certificate? ☐ Male ☐ Female

Race ***(Optional)***
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Ethnicity ***(Optional)***
☐ Hispanic, Latino/a, or Spanish origin ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin

Preferred Language ***(Optional)***
Is your primary or preferred language a language other than English? ☐ Yes ☐ No
If yes, which language: _____

Responsible party's information/legal guardian's information
(If patient is same as responsible party, leave this section blank)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Responsible party spouse information
(If patient is same as responsible party, fill in spouse information for patient)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Dependents of responsible party
(If patient is same as responsible party, fill in spouse information for patient.)

Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____

Number of adults and children in household _____

Monthly income
(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social security benefits _____
Child support received _____
Alimony received _____

Monthly living expenses
Patients who are presumptively eligible for financial assistance as described in **Saint Joseph Hospital's** Financial Assistance Policy are not required to complete this section.

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Childcare _____
Child support/alimony _____
Doctor/hospital bills _____
Car/auto insurance _____
Other monthly expenses _____

Total monthly expenses _____

Assets
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Health savings/Flexible Spending Account vehicle _____

AUTHORIZATION

I authorize **Saint Joseph Hospital** to obtain information from external credit reporting agencies. 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 my medical bills. I understand that this information provided may be verified by **Saint Joseph Hospital**, and I authorize **Saint Joseph 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 bill(s).

Signature of Applicant

_____

Date

_____

COMMENTS

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LETTER OF SUPPORT

Patient medical record number/account number

_____

Supporter's name

_____

Relationship to patient/applicant

_____

Supporter's address

_____

To **Saint Joseph Hospital**:

This letter is to advise that (patient's name) _____ receives little or no income and I am assisting with his/her living expenses. He/She/They has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of Supporter

_____

Date

_____