COOK COUNTY HEALTH

Illinois Resident
Application for Financial Assistance

We understand dealing with medical debt can feel overwhelming at times, but you don't have to overcome your challenges alone. We are here to help. Cook County Health& Hospitals System can assist with covering your medical costs. We have helped thousands of individuals find the right financial aid for their needs and we are here to support your needs.

Information You Should Know:

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. By completing this application, you will help Cook County Health & Hospitals System determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form and submit this application along with all the required verifications/*documents within 90 days following the date of discharge or receipt of outpatient care* to one of our hospitals listed below. You can submit your application and documents in-person, by mail, by email, or by fax.

Please Note: IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISOCUNTED 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.

JOHN H. STROGER JR. HOSPITAL
FINANCIAL ASSISTANCE OFFICE
1901 W. HARRISON AVE, RM 1290
CHICAGO, IL 60612
Phone: (866) 223-2817
Fax: (312) 864-9136

PROVIDENT HOSPITAL
FINANCIAL ASSISTANCE OFFICE
500 E. 51ST ST, RM 1003
CHICAGO, IL 60615
Phone: (866) 223-2817
Fax: (312) 572-2375

Financial Assistance Application

☐ Patient acknowledges that he/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.

1. PATIENT INFORMATION

Name_____ _____ _____
Last First Middle

Date of Birth_____-_____-_____ Social Security Number (not required if uninsured) _____

Address_____Apt Number_____

City _____County_____State_____Zip Code_____

Home Telephone_____-_____-_____Work Number_____-_____-_____Cell Number_____-_____-_____

Email address_____

Were you an Illinois Resident when care was rendered?_____

Were you involved in an alleged accident? _____

Were you a victim of an alleged crime? _____

2. PATIENT GUARANTOR (If applicable, may be patient's spouse, partner or the parent or guardian of a minor)

Name_____ _____ _____
Last First Middle

Address_____Apt Number_____

City _____County_____State_____Zip Code_____

Home Telephone_____-_____-_____Work Number_____-_____-_____Cell Number_____-_____-_____

3. FAMILY/HOUSEHOULD INFORMATION

Please provide the number of persons in patient's family/household?_____

Please provide the number of persons who are dependents of patient?_____

Please provide the age of each of patient's dependents in the table below:

Dependent	Age
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

4. FAMILY INCOME AND EMPLOYMENT INFORMATION

Is patient or patient's spouse or partner currently employed? _____Yes _____No

If yes, please provide the following information for all employers:

Employer Name	Address (Street Address, City, State, Zip Code)	Telephone

If patient is a minor, are patient's parents or guardians currently employed? _____Yes _____ No

If yes, please provide the following information for all employers:

Employer Name	Address (Street Address, City, State, Zip Code)	Telephone

If patient is divorced or separated or was a party to a dissolution proceeding, is patient's former spouse or partner financially responsible for patient's medical care per the dissolution or separation agreement? _____Yes _____No

What is your gross monthly family income (including cases in which a spouse or partner is a guarantor for patient or in which a parent or guardian is a guarantor for a minor patient)?

Sources of gross monthly family income (check all that apply):

_____Wages

_____Self Employment

_____Unemployment Compensation

_____Social Security

_____Social Security Disability

_____Veteran's Pension

_____Veteran's Disability

_____ Private Disability

_____Workers' Compensation

_____Temporary Assistance for Needy Families

_____Retirement Income

_____Child Support, Alimony or other Spousal Support

_____Other income

5. INSURANCE/BENEFIT INFORMATION

Do you or your spouse have access to any type of health insurance coverage? _____Yes _____No

If yes, please provide the following information for all employers:

_____Health Insurance

_____Medicare

_____Medicare Part D

_____Medicare Supplement

_____Medicaid

_____Veteran's benefit

6. MONTHLY EXPENSES

Note that if patient meets the presumptive eligibility criteria, as set forth in that application, or is otherwise presumptively eligible by virtue of the patient's family income, the patient is not required to complete the portion of this application addressing the monthly expense information.

Housing	Utilities	Food	Transportation	Childcare	Loans	Medical Expenses	Other Expenses	
$	$	$	$	$	$	$	$	$

Patient 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 provide may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provide in this application. I understand that if I knowingly provide untrue information in this application and/or *violate the CCH Patient Bill of Rights and Responsibilities*, 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.

Complaints or concerns with this uninsured patient discount application process or hospital financial assistance process maybe reported to the Health Care Bureau of Illinois Attorney General. The Bureau can be reached by clicking the following link Health Care Bureau Complaint Form (illinoisattorneygeneral.gov) **or 1-877-305-5145.**

_____ _____

Signature of Patient or Applicant Date

Please note: *Cook County Health & Hospitals System encourages all individuals to apply regardless of their race or immigration status.*
We will try our best to accommodate as many families as possible.