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 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.

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/HOUSEHOLD 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:

<table>
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<tr>
<th>Dependent</th>
<th>Age</th>
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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:

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Address (Street Address, City, State, Zip Code)</th>
<th>Telephone</th>
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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:

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<th>Employer Name</th>
<th>Address (Street Address, City, State, Zip Code)</th>
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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
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.

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<tr>
<th>Housing</th>
<th>Utilities</th>
<th>Food</th>
<th>Transportation</th>
<th>Childcare</th>
<th>Loans</th>
<th>Medical Expenses</th>
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**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)](http://illinoisattorneygeneral.gov) or 1-877-305-5145.

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Signature of Patient or Applicant ___________________________ Date ___________________________

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**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.*