



**Illinois Resident  
Application for Financial Assistance**

**Information You Should Know**

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application 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 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 with all the required verifications/documents within 90 days following the date of discharge or receipt of outpatient care.

**JOHN H. STROGER JR. HOSPITAL**  
FINANCIAL ASSISTANCE OFFICE  
1901 W. HARRISON AVE., ROOM 1690  
CHICAGO, IL 60612  
Phone Number: (866) 223-2817  
**FAX NUMBER:** (312) 864-9136

**PROVIDENT HOSPITAL**  
FINANCIAL ASSISTANCE OFFICE  
Room 1003  
CHICAGO, IL 60615  
Phone Number: (866) 223-2817  
**FAX NUMBER:** (312) 572-2375

**EMAIL:** mycookcountyhealth.com

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.

**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 Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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 Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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:

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, 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, 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 source (check all that apply):

- Health Insurance
- Medicare
- Medicare Part D
- Medicare Supplement
- Medicaid
- Veterans' 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	Child Care	Loans	Medical Expenses	Other Expenses	Total
\$	\$	\$	\$	\$	\$	\$	\$	\$

**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 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.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process maybe reported to the Health Care Bureau of the Illinois Attorney General. The Bureau can be reached by clicking the following link <https://illinoisattorneygeneral.gov/consumers/hcform.pdf> or 1-877-305-5145.

\_\_\_\_\_  
Signature of Patient or Applicant

\_\_\_\_\_  
Date