SWEDISHAMERICAN
HEALTH SYSTEM
www.swedishamerican.org

Financial Disclosure

Account Number(s)____

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help SwedishAmerican 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 60 days following the date of discharge or receipt of outpatient care. 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.

PRESUMPTIVE ELIGIBILITY

Please check any of the items listed below that apply.

_____Homeless
_____Medicaid
_____Patient is deceased with no estate
_____IHDA's Rental Housing Support Program
_____Patient has mental incapacitation with no one to act on patient's behalf
_____(WIC) Women, Infants and Children Nutrition Program Participant
_____(SNAP) Supplemental Nutrition Assistance Program Participant
_____Illinois Free Lunch and Breakfast Program Participant
_____(LIHEP) Low Income Home Energy Assistance Program Participant
_____Recipient of grant assistance for medical services
_____(TANF) Temporary Assistance for Needy families recipient
_____Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership

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INFORMATION

Patient Name __________________________________Date of Birth_________
Address____
City & State____
Telephone or cell phone number_______________________________________

Employer____
Social Security Number____
___________Number of persons who are dependents(exemptions on tax returns)
Ages of dependents____
Were you an Illinois resident at the time you received services_______________
Were you involved in an alleged accident ______________________________

Spouse/Partner or guarantor name_____________________________________
Address____
Employer____
Telephone or cell phone number_______________________________________

FAMILY INCOME
(Wages, Self-employment, Unemployment, Child Support, Social Security, etc)

______________________Patient (Gross per year)
______________________Spouse/Partner or guarantor (Gross per year)

Documentation for verification of Family Income is required to be included with this application. Required documentation may include **last year's tax return**, **social security statement** (if applicable), **last three paystubs**.

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.

Signature: ______________________________________ ___________
Patient or Applicant Date