Patient Name

DOB:

MR #

SwedishAmerican – A Division of UW Health
(University of Wisconsin Hospitals and Clinics Authority)

FINANCIAL DISCLOSURE

Date: ________________________________

Account Number: ______________________

You may be able to receive free or discounted care. Completing this application will help SwedishAmerican Hospital know if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form. Return it to the Business Office in person, by mail, by electronic mail, or by fax. You must do so within 60 days of discharge from the hospital or within 60 days of the date you received outpatient care.

If you do not have insurance, a social security number is not required to qualify for free or discounted care.
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 know whether you qualify for any public programs.

Presumptive Eligibility
You may be eligible for assistance before getting final approval. Please check any of the items 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
- ☐ Women, Infants, and Children (WIC) Nutrition Program participant
- ☐ Supplemental Nutrition Assistance Program (SNAP) participant
- ☐ Illinois Free Lunch and Breakfast Program participant
- ☐ Low Income Home Energy Assistance Program (LIHEP) participant
- ☐ Recipient of grant assistance for medical services
- ☐ Temporary Assistance for Needy Families (TANF) recipient
- ☐ Enrollment in an organized community-based program. Program provides access to medical care that assesses and documents limited low-income financial status as a criterion for membership.

Fill out the blanks below.

Patient Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________

City and 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? ☐ Yes ☐ No

Were you involved in an alleged accident? ☐ Yes ☐ No

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): ____________________

Proof of family income must be included with this application. Options may include **last year's tax return, social security statement (if applicable), last three pay stubs, two (2) bank statements and proof of Illinois residence.**

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By signing this form, (1) I certify that the information in this application is true and correct to the best of my knowledge. (2) I acknowledge that I have made a good faith effort to provide all information requested to help the staff know whether I am eligible for financial help. (3) I will apply for any state, federal or local assistance to help pay for this hospital bill. (4) I understand that the information given may be verified by the hospital. (5) I authorize the hospital to contact third parties to verify the accuracy of the information I have given. (6) I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial help, any financial support granted to me may be reversed, and I will be responsible to pay the hospital bill.

Signature of Patient/Representative: ______________________________________ Date: __________ Time: ____________

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: ____ Relationship: ___________________________________

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ Other: ____________________________

Reviewed by: ____ Date: ___________ Time: ___________