Presence Health®

HOSPITAL FINANCIAL ASSISTANCE APPLICATION COVER LETTER

Thank you for choosing a Presence Health hospital for your healthcare services. We offer a variety of financial assistance programs to meet our patients' needs. Such assistance programs apply **only** to Presence Health hospital charges. Please be aware you will receive separate bills from physicians or other health care providers for care, treatment, or services provided while you are a hospital inpatient or outpatient. The Financial Assistance Provider Participation List on the Presence Health website (go to http://www.presencehealth.org/financialassistance) states whether such providers apply the hospital Financial Assistance discount (if any) to the charges for their services while you are in the hospital.

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Presence Health 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 will help Presence Health determine whether you qualify for any public programs. Applying for such programs may be required prior to applying for a Financial Assistance Program. We will assist patients with the identification of state funded public programs and the enrollment process.

Please complete this form and submit it to the hospital in person or by mail, e-mail, or fax to apply for free or discounted care. In completing this form, you acknowledge that you have made a good faith effort to provide all information requested in the application to assist Presence Health in determining your eligibility for financial assistance.

Presence Health Financial Assistance and other Patient Discount Programs include:

Program	Available to	Description	How to Apply
Financial Assistance	Uninsured and Insured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines	Complete the Financial Assistance Program Application
Automatic Uninsured Self-Pay Discount	Uninsured Patients	Provides an automatic 40% discount to your hospital bill	No application necessary
Catastrophic Discount	Uninsured and Insured Patients	Limits the out-of-pocket costs when medical debts specific to medical care at our Hospitals exceed 15% of the patient's family gross income for patients with family income up to 600% of the Federal Poverty level	Determine if your out-of-pocket expenses exceed 15% of family gross income. If so, complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements	Contact a Financial Counselor* or Customer Service at 888-740-4111

To help us determine if you are qualified to receive financial assistance, please complete, sign and return the enclosed application along with copies of the following applicable documents:

1. Proof of Income: One (1) of the following:
    a. Most recent federal income tax return (*preferred)* or state income tax return
    b. Most recent W-2 form and 1099 forms
    c. Copies of 2 most recent paycheck stubs
    d. Written income verification from an employer, if paid in cash
    e. Other reasonable form of third-party income verification deemed acceptable to Presence Health
2. Driver's License or State-issued ID
3. Social Security Award Letter (*if applicable*) or Unemployment Compensation Benefit Award Letter (*if applicable*)
4. Room and Board Statement (*if no income*) – available at: www.presencehealth.org/financialassistance

Return completed form and supporting documents to:
Presence Health Financial Counseling
1000 Remington Blvd., Suite 110
Bolingbrook, IL 60440

We will respond to you within a reasonable time of receiving your completed application and supporting documents. If you have any questions or need additional assistance, please contact us at 888-740-4111 or visit www.presencehealth.org/financialassistance to obtain additional information on the Financial Assistance Programs available.

Hospital Financial Assistance Application Date of Application: _____

NOTE: This application is for Presence Health Hospital charges only and does not include independent physician professional charges for care they provided to you while in the hospital or a hospital outpatient center. Please see the Financial Assistance Provider Participation List on the Presence Health website for a list of providers who will apply the Financial Assistance discounts determined under the hospital's Financial Assistance Policy, for their services during your hospital inpatient or outpatient visit.

Program Applying For:

- ☐ Financial Assistance (Free/Discounted Care)
- ☐ Catastrophic Discount

PATIENT INFORMATION *: **-PLEASE PRINT ALL INFORMATION-**				
Last Name	First Name	M.I.		
*** If the patient is a minor or full-time student, please list parent(s)/guardian(s) as co-applicant**				
APPLICANT (PATIENT/PARENT) INFORMATION: Relationship to Patient:(circle): Self Spouse Parent Other **Marital Status (circle):** Single Married				
Last Name	First Name	M.I.	DOB	Social Security Number (not required if uninsured)
Address			Phone	
Current Employer	Street Address		Phone	Years Employed
CO-APPLICANT (SPOUSE/PARENT) INFORMATION: Relationship to Patient:(circle): Self Spouse Parent Other				
Last Name	First Name	M.I.	DOB	
Address			Phone	
Current Employer	Street Address		Phone	Years Employed

Total Number of Dependents: (other than self and co-applicant)	**Dependent Name**	**Date of Birth**	**Relationship**

INCOME INFORMATION:
List all contributing gross household income, including cases in which a spouse or partner is guarantor for patient or in which a parent or guardian is guarantor for a minor. Include sources such as: gross wages, salaries, self-employment, unemployment compensation, social security benefits, government pensions, disability, dividends, interest, workers compensation, training stipends, regular support from family members not living in the household, child or spousal support, alimony, private pensions, insurance and annuity payments, retirement income, income from rents, royalties, estates, trusts, veteran stipends, or Temporary Assistance for Needy Families (TANF)

Monthly Household Income Sources Check those that apply and give amounts	
☐ Employment Income	$
☐ Social Security	$
☐ Disability	$
☐ Unemployment	$
☐ Spousal/Child Support	$
☐ Rental Property	$
☐ Investment Income	$
☐ Other:	$
Total Monthly Income	$

If you do not have monthly income, you will need to provide information as to who is providing you with room and board. Please complete the Room and Board Statement as documentation that you do not have monthly income.
Available at www.presencehealth.org/financialassistance

INSURANCE/BENEFIT INFORMATION
Which forms of insurance do you currently have? (Select all that apply)
For each selected, please provide supporting documentation (if applicable)

- ☐ Private Health Insurance
- ☐ Medicare
- ☐ Medicare Part D
- ☐ Medicare Supplement
- ☐ Medicaid
- ☐ Veterans Benefits
- ☐ I do not have insurance

ADDITIONAL INFORMATION/COMMENTS:

Applicant Signature	Date	Co-applicant Signature	Date

SIGNATURE: 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.

Return completed form and supporting documents to:
Presence Health
Financial Counseling
1000 Remington Blvd., Suite 110
Bolingbrook, IL 60440

If you have any questions or need additional assistance, please contact us at 888-740-4111 or visit www.presencehealth.org/financialassistance to obtain additional information on our Financial Assistance Programs.

Financial Counselors:

- Presence Covenant Medical Center: 888-693-2252, Option 4
- Presence Saint Joseph Hospital - Elgin: 847-695-3200 ext. 3220, 5294
- Presence Saint Joseph Medical Center: 815-725-7133 ext. 5649, 5695
- Presence St. Mary's Hospital: 815-937-2028
- Presence Mercy Medical Center: 630-801-2654
- Presence United Samaritans Medical Center: 888-693-2252, Option 4
- Presence Holy Family Medical Center: 847-954-5485
- Presence Resurrection Medical Center: 773-792-5010
- Presence Saint Francis Hospital: 847-316-2402 or 847-316-2012
- Presence Saints Mary and Elizabeth Medical Center: 312-770-3164 or 312-770-2897
- Presence Saint Joseph Hospital - Chicago: 773-665-6476