Presumptive Charity

Patient Name _____

Date of Service_____

Total Charges _____

The following is a listing of types of accounts where financial assistance is considered to be automatic and may be approved for financial assistance without a financial assistance application or documentation of Income:

☐ Guarantors with a history of bad debt closed and returned or inability to pay by our 3rd party collection agency.

☐ Applicants whose socio-economic data clearly indicates an inability to pay.

☐ Reside at a homeless shelter or receipt of care from a homeless clinic.

☐ Deceased and no estate is located.

☐ Letter or Record of participation in the following programs: Women, Infants, and Children program, TANF, SNAP, WIC or prior Medicaid Eligible.

☐ Health condition of patient, age of patient, employment status, size of debt and marital status combined to present a high likelihood of inability to pay

☐ Other circumstances which a reasonable person would conclude the debt for services will not be paid.

☐ Experian Financial Clearance tool

☐ Prior charity approval

☐ Out-of-state Medicaid

Loretto Hospital

645 S. Central Ave. Chicago, IL. 60644

Patient _____ **Date:**_____

Account:_____

Below is a list of documentation that you **MUST** provide with your application for financial assistance . Eligibility is based on current Federal Poverty Guidelines.

- Copy of last year's W2 forms, (4) pay stubs, SSI award letter
- Copy of last year's complete tax form.
- Room and Board Letter if applicable or Rent Receipt
- Driver's License (Photo I.D.)
- Social Security card

Please feel free to contact our office if you have any questions or concerns Monday –Friday from 8:00am-5:00pm office :773-854-5083 cell:773-762-9748 Fax: 773-626-7902

Thank you,

Loretto Hospital

LORETTO HOSPITAL
Financial Assistance Application

Important: You may be able to receive free or discounted care: Completing this application will help Loretto 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. While a social security number is not required for some public aid programs, including Medicaid, providing a social security number 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 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.

Internal Use Only:
Application Date: _____ MRN: _____

Account Number: _____

Approved %: _____ Denied/Reason: _____ Pt's Bal Due: _____

Patient Information:

Patient Name: _____ Phone #: _____

Patient Date of Birth: _____

Patient Address: _____

_____

Patient an Illinois resident at time of service? (circle one) YES NO

Patient involved in an alleged accident? (circle one) YES NO

Patient victim of an alleged crime? (circle one) YES NO

Patient Social Security Number (not required if uninsured): _____

Patient telephone or cell phone number: _____

Patient email address (if applicable): _____

Applicable: Guarantor Information (If patient is a minor or spouse/partner is responsible for patient):

Guarantor Name: _____

Guarantor Address: _____

_____

Guarantor telephone or cell phone number: _____

Family Household Information:

Number of persons in the patient's family household: _____

Number of persons who are dependent of the patient: _____

List the ages of the dependents in the household.

Dependents	Age
Dependents 1	
Dependents 2	
Dependents 3	
Dependents 4	
Dependents 5	
Dependents 6	

Patient's Family Income and Employment Information:

Patient – are you employed? Circle one YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

Spouse of patient – are you employed? Circle one YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

If the patient is a minor, is the parent or guardian of the minor employed? Circle one YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

Marital status of the patient (please circle one):

Single Married Widowed Separated* Divorced*

*If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order? (circle one) YES NO

Gross monthly family income:

$	Total household employment income (including self-employed)
$	Unemployment compensation
$	Social Security
$	Social Security Disability
$	Veterans' pension
$	Veterans' disability
$	Private disability
$	Workers' Compensation
$	Temporary Assistance for Needy Families
$	Retirement Income
$	Child Support, alimony or other spousal support
$	Other Income
$	Total gross monthly family income

'lease provide documentation of the following:
'aycheck stubs (last 4)
lenefit statements
.ward letters
:ourt orders
ederal tax returns
ther documents in support of income
Ex. Bank Statement

Are you enrolled I any of the following? (circle all that apply)
Women, Infants and Children Nutrition Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)
Illinois Free Lunch and Breakfast Program
Low Income Home Energy Assistance Program (LIHEAP)
Any community-based program that provides access to medical care based on low-income financial status

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nsurance/Benefit Information:

oes the patient have medical insurance? (circle one) YES NO

yes, please specify:

'pe of coverage (please circle one):

ealth Medicare Medicare Part D Medicare Supplement Medicaid Veterans

sured Member Name: _____

surance Co. Name: _____

bscriber ID: _____

Asset and estimated asset value information:

$	Checking
$	Savings
$	Stocks
$	Certificates of deposit
$	Mutual funds
$	Health savings/Flexible spending account
$	Real property
$	*Do you own a home or property?* *Yes* or *No*
$	Automobiles or other vehicles
$	Make: _____ Model: _____ Year: _____
$	Make: _____ Model: _____ Year: _____
$	Make: _____ Model: _____ Year: _____
$	Total assets and estimated assets information

Monthly expense information and estimated expense figures:

$	Housing (rent or mortgage)
	If nothing, please explain:
$	Utilities
$	Gas
$	Electric
$	Phone
$	Food
$	Transportation (car/bus fare, etc.)
$	Child Care
$	Loans (student, payday, etc.)
$	Medical expenses
$	Other expenses
$	Total monthly expense information

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 reverse, and I will be responsible for the payment of the hospital bill.

Patient or applicant's signature: _____ Date: _____

If a patient meets the presumptive eligibility criteria of Loretto Hospital or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL SERVICES ONLY. YOU MAY RECEIVE A BILL FOR THE PHYSICIAN PROFESSIONAL SERVICES.

State of Illinois
Department of Human Services

APPROVED REPRESENTATIVE CONSENT FORM

1 (PERMANENT)

APPROVED REPRESENTATIVE'S INFORMATION (PLEASE PRINT LEGIBLY OR TYPE)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

CLIENT SECTION

I want the person named above to apply for cash, medical and/or Food Stamp benefits for me and/or my family. I understand that I am still responsible for the information that my representative gives to the Department.

Client's Signature (or mark): _____

Signature of Witness
(if client signed with a mark): _____

Date: _____

REPRESENTATIVE SECTION

I have talked to the client about why they are signing this form. I (or the company I represent) will submit to the Illinois Department of Human Services a request for cash, medical, and/or Food Stamp benefits on their behalf. I have also told this client that DHS needs to have certain facts to make a correct decision on their eligibility for benefits.

I have told the client that they need to cooperate with DHS to obtain any needed verification(s) for the eligibility decision.

Representative's Signature: _____

Relationship to Client: _____