Saint Francis Hospital

02/28/2025

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help **Saint Francis Hospital** determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Three ways to submit this application, please see page 7.

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 **Saint Francis Hospital** determine whether you qualify for any public programs. For any application questions marked "optional," your response (or non-response) will not have any impact on the outcome of the application.

Please complete this form and submit it to **Saint Francis Hospital** by mail, by electronic mail (email), or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your application for up to 240 days following the first billing statement for your care. By submitting this application, you acknowledge that you have made a good faith effort to provide all information request in the application to assist **Saint Francis Hospital** in determining whether the patient is eligible for financial assistance. If you have any questions on the application process, you may contact **Saint Francis Hospital, Patient Financial Services** with questions or concerns at **833-272-7581**.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General. The Health Care Bureau's toll-free hotline is 877-305-5145 (TTY 800-964-3013).

Patient Information

Date _____ Account number _____

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Gender Identity ***(Optional)*** Do you think of yourself as:
☐ Male ☐ Female
☐ Transgender man/trans man/female-to-male (FTM)
☐ Transgender woman/trans woman/male-to-female (MTF)
☐ Genderqueer/gender nonconforming neither exclusively male nor female
☐ Additional gender category (or other)

Gender Identity ***(Optional)***
What sex was originally listed on your birth certificate? ☐ Male ☐ Female

Race ***(Optional)***
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Ethnicity ***(Optional)***
☐ Hispanic, Latino/a, or Spanish origin ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin

Language ***(Optional)***
Do you speak a language other than English? ☐ Yes ☐ No If yes, which language: _____

Responsible party's information/legal guardian's information
(If patient is same as responsible party, leave this section blank)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Responsible party spouse information
(If patient is same as responsible party, fill in spouse information for patient)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Address _____

Social Security Number: ***(Optional)*** _____

Employer _____ Employment status _____

Dependents of responsible party
(If patient is same as responsible party, fill in spouse information for patient.)

Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____
Name _____ Birth date _____ Relationship to responsible party _____

Number of adults and children in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income	_____	Child support received	_____
Applicant spouse income	_____	Alimony received	_____
Social security benefits	_____	Rental property income	_____

Monthly living expenses

Patients who are presumptively eligible for financial assistance as described in **Saint Francis Hospital's** Financial Assistance Policy are not required to complete this section.

Mortgage/rent	_____
Utilities	_____
Phone (landline)	_____
Cell phone	_____
Groceries/food	_____
Cable/internet/satellite tv	_____
Car payment	_____
Childcare	_____
Child support/alimony	_____
Credit cards	_____
Doctor/hospital bills	_____
Car/auto insurance	_____
Home/property insurance	_____
Medical/health insurance	_____
Life insurance	_____
Other monthly expenses	_____
Total monthly expenses	_____

Assets

Cash/savings/checking accounts	_____
Stocks/bonds/investments/CD(s)	_____
Other real estate/secondary residence	_____
Boat/RV/motorcycle/recreational vehicle	_____
Collector automobiles/non-essential automobiles	_____
Health savings/Flexible Spending Account vehicle	_____

AUTHORIZATION

I authorize **Saint Francis Hospital** to obtain information from external credit reporting agencies. 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 my medical bills. I understand that this information provided may be verified by **Saint Francis Hospital**, and I authorize **Saint Francis 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 bill(s).

Signature of Applicant _____

Date _____

COMMENTS

LETTER OF SUPPORT

Patient medical record number/account number _____

Supporter's name _____

Relationship to patient/applicant _____

Supporter's address _____

To **Saint Francis Hospital**:

This letter is to advise that (patient's name) _____ receives little or no income and I am assisting with his/her living expenses. He/She/They has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of Supporter _____

Date _____

Dear Patient/Applicant,

Saint Francis Hospital is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete the application, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the "Letter of Support" form.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received for the application to be considered. We are unable to process or consider incomplete applications.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

MAIL
Please print and mail your completed application to the following address:

Saint Francis Hospital
Attention: Patient Financial Services
P.O. Box 74008843
Chicago, IL 60674-8843

FAX
Please print and fax your completed application to **734-458-3236**.

EMAIL
Please email your completed application to **IL-cbovendorteam@primehealthcare.com**.

If you have any questions about this application, please call Patient Financial Services at **833-272-7581**.

Sincerely,
Saint Francis Hospital
Patient Financial Services