



Sinai Health Systems • California Avenue at 15th Street • Chicago, IL 60608

REQUEST FORM FOR FINANCIAL ASSISTANCE

Date:

Dear Patient,

It is the mission of Sinai Health System to provide necessary quality medical care regardless of race, creed, color, sex, national origin, physical abilities, age, or the ability to pay.

Sinai Health System has a financial assistance program (FAP) to assist patients who:

- Have NO medical insurance
- Do NOT qualify for Public Aid
- Have a family income that meets the Federal Poverty Guidelines

Please complete the enclosed application, signed and dated, with the supporting documentation. Upon receipt of your application and supporting documentation, a determination of eligibility will be made and notification sent to you within 10 business days of receipt. ***If you are waiting for a determination of eligibility from Public Aid you must have a denial before you can be approved for financial aid from the hospital.***

For further information on the FAP program at Mount Sinai Hospital, please contact one of the financial counselors at: Mount Sinai Hospital: **773-257-6872 or 773-257-5172**

What do you need to bring with you?

1. Photo ID
2. Proof of income – tax return, W-2's and three current pay stubs
3. If you are paid in cash a letter from your employer on company letterhead stating income and length of employment
4. If income verification is NOT available, write a letter of all facts supporting the need for assistance
5. Birth certificates for minor or dependent children
6. Copy of any other source of income, i.e. Social Security, pension check, child support, etc
7. Utility bill, i.e. electric, gas, cable, cell
8. Denial letter from Public Aid

Where do I go?

The Financial Counselors office is located in room C1200, front lobby at Mount Sinai Hospital and in the front lobby at Schwab Rehabilitation Hospital where they are available from 8:00 am to 4:00 pm, Monday – Friday.

We have attached an application for financial assistance and a self-addressed envelope. Please complete the application, sign and return it as soon as possible for determination of eligibility for assistance.

Thank You,
Financial Counselors

FINANCIAL ASSISTANCE PROGRAM
APPLICATION: FINANCIAL STATEMENT

I hereby request that Sinai Health Systems make a written determination of my eligibility for financial assistance for hospital services (non-physician fees). I understand that the information I provide concerning my family size and income is subject to verification by the hospital. I also understand that if the information is determined to be false, I will be liable for all charges for services that I receive.

1. Patient and Responsible Party Information

Patient Name: _____
First Middle Last

Responsible Party (If different from patient):

First Middle Last

Patient's Address: _____
Number and Street

City State Zip Code

Patient's Phone: _____ Cell: _____ Work: _____

2. Employer Information

Occupation: _____

Employer: _____

Employer Address: _____
Number and Street

City State Zip Code

3. Income Information (Please include your most recent W2 and Tax return)

	Total for 1 Month	Total Annual Income
Wages		
Public Assistance		
Unemployment Compensation		
Workers Compensation		
Pension		
Child Support		
Income from Dividends		
Interest, Rent		
Other		
Total		

4. Family Size Information

Total Number of Dependents: *(Number of individuals for whom you are financially responsible)*

Name	Relationship	Age	Birth Certificate

5. Date of Birth: _____

6. Inpatient _____ or Outpatient _____

7. Type of Medical Service *i.e Radiology, Ultrasound, Chemo, Therapy etc:*

8. Account(s): _____

I affirm that the information that has been provided in this Financial Statement is true and correct to the best of my knowledge.

 Signature of Patient / Responsible Party

 Date

 Sinai Health System Financial Counselor and Phone

 Date