SINAI

Sinai Health System California Avenue at 15th Street • Chicago, IL 60608 • (773) 542-2000 • TDD (773) 542-0040

FINANCIAL ASSISTANCE APPLICATION INFORMATION

The mission of Sinai Health System is to improve the health of the individuals and communities it serves, regardless of an individual's ability to pay.

In keeping with its mission, Sinai has a financial assistance program to help patients pay for essential medical services provided at its affiliated hospitals. This program assists patients who are unable to access public programs, such as Medicare, Medicaid, Crime Victims Assistance, or other programs. You may be eligible for free or discounted health care services. Completing this application will help Mount Sinai Hospital, Schwab Rehabilitation Hospital, Holy Cross Hospital, and Sinai Medical Group determine if you can receive free or discounted services or may be eligible for 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, but it will help to determine whether you qualify for any public programs. A Social Security Number is required for some public programs, including Medicaid. It also assists Sinai in using Electronic Information Technology to make financial assistance determinations.

Financial Assistance Applications are available to any patient who expresses a need for financial help. Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care. Financial counselors are available at Mount Sinai Hospital, Holy Cross Hospital, or Schwab Rehabilitation Hospital between 7:30 a.m. and 4:30 p.m. The financial Counselor will need to verify your identity, income, family size, and residency.

Along with your completed application, **please include:**

- Government-issued Photo Identification (if available)
- Proof of Income
  - IRS tax returns for the most recent calendar year;
  - All W-2 and/or 1099 forms for the most recent calendar year;
  - Last two current paystubs or any official documents from an employer if paid in cash;
  - One other reasonable form of income verification deemed acceptable by Sinai, such as pension documentation, employer's written verification (if paid in cash), social security benefits or child support checks; and/or
  - A room and board letter;
- Proof of Dependents
  - Birth certificates of each dependent child, or other supporting documentation.
- Proof of Illinois Residency. *You only need to provide one (1) of the following forms of proof:*
  - Any of the documents requested as part of income verification;
  - Illinois Voter registration card;
  - A lease agreement;
  - A vehicle registration card;
  - Mail addressed to the uninsured patient at an Illinois address from a governmental or other credible source;
  - Alternative sources may be utilized, when available, to validate residency.
- If you needed healthcare because you were the victim of a crime, please bring a copy of the police report.

In certain cases, you may be offered a charity discount without an application. **Before submitting an application for financial assistance, please ask one of the financial counselors whether you qualify for a charity discount!** You may reach a financial counselor by calling (773) 257-1777, or by visiting your Mount Sinai Hospital, Holy Cross Hospital or Schwab Rehabilitation Hospital.

FINANCIAL ASSISTANCE APPLICATION
FINANCIAL STATEMENT

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help the 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. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help Sinai determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic 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.

1. Patient and Responsible Party Information

Patient Name: _____
First Middle Last

Patient's Address: _____
Number and Street

_____
City State Zip Code

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

Patient's email address: _____

Patient's date of birth: _____

Patient's Social Security Number (not required to provide if you are uninsured) _____

Responsible Party *(if different from patient): Parent or Guardian or divorced or separated former spouse/partner responsible for the patient's medical care per a dissolution/separation agreement*

_____
First Middle Last

Is there other insurance/ benefits from Medicare, Medicaid, Veterans' benefits, or any other health insurance and supplemental plans? _____

Is this care provided related to an automobile, work, or industrial accident?_____

2. Employer Information

Employer: _____

Employer Address: _____
Number and Street

_____
City State Zip Code Telephone Number

Spouse/Partner Employer Information

Employer: _____

Employer Address: _____
Number and Street

_____
City State Zip Code Telephone Number

Parent or Guardian Information Employer Information (for Pediatric Patients)*

Parent/Guardian 1.

Employer: _____

Employer Address: _____
Number and Street

_____
City State Zip Code Telephone Number

Parent/Guardian 2.

Employer: _____

Employer Address: _____
Number and Street

_____
City State Zip Code Telephone Number

3. **Family Income Information (Please provide proof of reported income)**

	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

If you meet the presumptive eligibility criteria established in Section 4500.40 of the Illinois Administrative Code or are otherwise presumptively eligible by virtue of your family's income, you are not required to complete this Section of the Financial Assistance Application.

5. **Expenses**

Expense	Monthly Payments	Balance (where applicable)
Mortgage/ Rent	$	$
Utilities: Gas Electric Water/ Sewer Phone Cable	$ $ $ $ $ $	
Food (use $160.00 per family member per month if amount is unknown)	$	
Charge Cards/ Other Charge Cards/ Other Charge Cards/ Other	$ $ $	$ $ $
Car Payment Make:_____ Year_____	$	$
Other Medical Expenses Other Medical Expenses	$ $	$ $
Additional Expenses _____ _____ _____		
Total All Expenses	$	$

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.

_____ _____

Signature of Patient/Responsible Party Date