Ann & Robert H. Lurie Children's Hospital of Chicago™

FINANCIAL ASSISTANCE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Lurie Children's 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 Numbers is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but 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, by electronic mail, or by fax to apply for free or discounted care to the address below.

Ann & Robert H. Lurie Children's Hospital of Chicago
225 East Chicago Avenue, #44, Chicago, IL 60611
Tel: 877.924.8200 | Fax: 312.227.9501

Patient or Guardian(s) acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the Hospital in determine whether the patient is eligible for financial assistance.

Patient Account Number(s): Guarantor Number:

PATIENT INFORMATION

Last Name	First	M.I.	Date of Birth	Social Security Number	Family Size

Street	City	State	Zip Code	Home Phone

Employer	Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

GUARANTOR INFORMATION (PARENT/GUARDIAN)

Relationship to Patient
☐ Father ☐ Mother ☐ Other

Last Name	First	M.I.	Age	Social Security Number (optional)

Street	City	State	Zip Code	Home Phone

Employer	Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

GUARANTOR INFORMATION (PARENT/GUARDIAN)

Relationship to Patient
☐ Father ☐ Mother ☐ Other

Last Name	First	M.I.	Age	Social Security Number (optional)

Street	City	State	Zip Code	Home Phone

Employer	Address	Cell Phone

City	State	Zip Code	Monthly Income	Work Phone

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PATIENT/FAMILY E-MAIL CONTACT INFORMATION	

PRESUMPTIVE ELIGIBILITY PROGRAM			
You may qualify for financial assistance if you are currently enrolled in one of the specific assistance programs listed below. Please review the programs and indicate if you are currently enrolled in the program. (Proof of current enrollment in the program must be supplied but no other documentation will be necessary, and the Monthly Income information requested above is not required.)			
		Please indicate in the column to the left if you are currently enrolled in any of the following programs.	
		Women, Infants and Children Nutrition Program (WIC)	
		Supplemental Nutrition Assistance Program (SNAP)	
		Illinois Free Lunch and Breakfast Programs	
		Low Income Home Energy Assistance Program (ILHEAP)	
		Community Based program providing access to medical care	Specify Name:
		Grant Assistance for medical services	Specify Name:
		Temporary Assistance for Needy Families (TANF)	
		IHDA's Rental Housing Support Program	

If you do not qualify for the programs listed above, please provide the following information for each applicable family members

1) a copy of the most recent tax return (1040)
2) a copy of the last three pay stubs for all employed family members
3) if applicable, copy of Social Security Award
4) if applicable, copy of Unemployment Statement
5) other income (child support, alimony, letter from employer if paid in cash)

Note: Although typically the Hospital is able to determine eligibility utilizing the documents detailed above. Further clarification may be requested to assist in the qualification process, including the following items: Checking and Savings account information; Stocks; Certificates of Deposit; Mutual Funds; Real property; and Health savings/Flexible spending account information.

Applicant Certification: 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 authorized the hospital to contact third parties if necessary 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.

Applicant Signature:_____ Date: _____