Swedish Covenant Hospital

Thank you for choosing Swedish Covenant Hospital for your healthcare needs.

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Swedish Covenant 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 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.

Please include supporting documentation of income. Examples of supporting documentation (provide any that fit your situation): current paystubs, receipts from self-employment, copies of unemployment checks, copies of social security checks, list of employer cash payment or any other written document. If your employer(s) pay you in cash, state your earnings in writing in this application for the past two pay periods.

Contact the Financial Service Center (773-989-3841) if you need help in understanding what you need to do. Completed applications can be mailed or faxed to the following:

Swedish Covenant Hospital
Attention: Financial Service Center
5145 N. California Avenue
Chicago, IL 60625

Fax: 773-878-6838

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.

FINANCIAL ASSISTANCE APPLICATION

Date of Application: _____

Patient Name: _____

Account Number (s): _____

Total Patient Responsibility: _____

Information Due Date: _____

Patient Statement

Number of persons in patient's family/household_____

Number of persons who are dependents of the patient_____

Ages of patient's dependents_____

Provide current earnings and income (wkly, bi-wkly, monthly, annual)

Patient_____ _____

Spouse_____ _____

Other_____ _____

Please include supporting documentation of income. Examples of supporting documentation (provide any that fit your situation): current paystubs, receipts from self-employment, copies of unemployment checks, copies of social security checks, list of employer cash payment or any other written document. If your employer(s) pay you in cash, state your earnings in writing in this application for the past two pay periods.

Comment: _____

_____

_____

_____

Assets and estimated asset value information, which are limited to the following:

Checking account(s):_____

Savings accounts(s):_____

Stocks: _____

Certificates of deposit: _____

Mutual funds: _____

Automobiles: _____

Real Property: _____

Health savings/flexible spending accounts: _____

Monthly expenses information and estimated expense figures, which are limited to:

Housing: _____

Utilities:

Electric _____

Heat_____

Water_____

Food: _____

Transportation: _____

Child care: _____

Loans: _____

If the patient meets the presumptive eligibility criterion established in Section 4500.40 or is otherwise presumptively eligible by virtue of the patient's income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures set out in subsection (g).

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 authorize the hospital to contact third parties to verify the accuracy of the information provided. 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 payment of the hospital bill.

_____

Patient/applicant signature/date