RML

SPECIALTY HOSPITAL

5601 S. County Line Road
Hinsdale, IL 60521
(630) 286-4516

3435 W. Van Buren St.
Chicago, IL 60624
(773) 826-6300

Application for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help RML Specialty Hospital (aka RML Chicago) 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, 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.

I. PATIENT INFORMATION

Patient Name:

____
First   Middle   Last

____
Address   City   State   Zip Code

Date of Birth:____________________

Currently an Illinois Resident? Yes / No

Was your hospitalization at RML the result of an alleged accident? Yes / No

Social Security Number: ____________________ (Not required if you are Uninsured)

Telephone Number: ____________________

Cell #: ____________________

Email Address: ____________________________________

PATIENT GUARANTOR INFORMATION:
If the spouse or partner is a guarantor for the patient or in which a parent or guardian is a guarantor for a minor, provide the following information:

Guarantor Name: ______________________________

Guarantor Address: ____

Guarantor Telephone Number: ____

II. FAMILY / HOUSEHOLD INFORMATION

Number of persons in the patient's family/household: _________

Number of persons who are dependents of the patient: _________

Ages of patient's dependents: ____

III. PATIENT'S FAMILY INCOME AND EMPLOYMENT INFORMATION

Is the patient, patient's spouse or partner currently employed? Yes / No

If the patient is a minor, are either the parents or guardian of patient currently employed? Yes / No

If yes to either question above please complete the following employer Information.

Circle One: Patient Spouse Partner Parent Guardian

Employer Name: ____

Employer Address: ____

Employer Telephone Number: _______________________________________

Circle One: Patient Spouse Partner Parent Guardian

Employer Name:____

Employer Address:_______________________________________

Employer Telephone Number:________________________________

Circle One: Patient Spouse Partner Parent Guardian

Employer Name:____

Employer Address:_______________________________________

Employer Telephone Number:________________________________

If patient is divorced or separated or a party to a dissolution proceeding, is the former spouse or partner financially responsible for a patient's medical care per the dissolution of separation agreement? Yes / No

<u>GROSS MONTHLY FAMILY INCOME</u>

	Patient	Partner or Spouse	Parent or Guardian
Wages			
Self-employment			
Unemployment Compensation			
Social Security			
Pension / Retirement Income			
Disability (all types)			
Worker's Compensation			
Temporary Assist. – Needy Family			
Child Support & Alimony			
Other Income Sources			
Total Monthly Income Sources			

Provide documentation of all sources of family income. Examples of such documentation include 2 most recent paycheck stubs, benefit statements, award letters, court orders, federal tax returns or other documentation to substantiate your income sources.

IV. INSURANCE/BENEFIT INFORMATION

Please indicate with an X if you have the following health insurance:

Medicare: ______
Medicaid ______
Medicare Supplement: ______
Private/Commercial Insurance: ______
Veteran's Benefits: ______

V. ASSET AND ESTIMATED ASSET INFORMATION

	Amount
Checking Account	________
Savings Account	________
Stocks	________
Certificates of Deposit	________
Mutual Funds	________
Health Savings Account	________
Flexible Spending Account	________
Real Property	________
Automobile(s)	________
Total Assets	________

VI. MONTHLY EXPENSES AND ESTIMATED EXPENSES

	Amount
Housing	________
Utilities	________
Food	________
Transportation	________
Child Care	________
Loans	________
Medical Expenses	________
Other Expenses	________
Total Monthly Expenses	________

Note: If patient meets presumptive eligibility criteria for free care or is otherwise presumptively eligible by virtue of patient's family income, the patient is not required to complete this section VI – Monthly Expenses and Estimated Expenses.

VII. 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 (RML Specialty Hospital, aka RML Chicago) 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, and financial assistance granted to me may be reversed, and I will be responsible for payment of the hospital bill.

______________________________________ __________________

Patient or Applicant Signature Date