COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Illinois Resident
Application for Financial Assistance

Information You Should Know

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Cook County Health & Hospitals System 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 with all the required verifications/documents within 90 days following the date of discharge or receipt of outpatient care.

JOHN H. STROGER JR. HOSPITAL
FINANCIAL ASSISTANCE OFFICE
1901 W. HARRISON AVE., ROOM 1690
CHICAGO, IL 60612
Phone Number: (866) 223-2817
FAX NUMBER: (312) 864-9136

OAK FOREST HEALTH CENTER
FINANCIAL ASSISTANCE OFFICE
15900 S. CICERO. BUILIDNG E
OAK FOREST, IL 60453
Phone Number: (866) 223-2817
FAX NUMBER: (708) 633-3427

PROVIDENT HOSPITAL
FINANCIAL ASSISTANCE OFFICE
OLD SEGSTACKE BLDG, 1ST FL
CHICAGO, IL 60615
Phone Number: (866) 223-2817
FAX NUMBER: (312) 572-2375

EMAIL: mycookcountyhealth.com

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 INFORMATION

Name _____ _____ _____
Last First Middle

Date of Birth _____-_____-_____

Address_____Apt Number_____

City _____County _____State _____Zip Code _____

Home Telephone Number_____-_____-_____Work Number _____-_____-_____Cell Number _____-_____-_____

Email address _____

Were you an Illinois Resident when care was rendered? _____

Were you involved in an alleged accident? _____

Were you a victim of an alleged crime? _____

of

2. PATIENT GUARANTOR (if applicable, may be patient's spouse, partner or the parent or guardian of a minor)

Name _____ _____ _____
Last First Middle

Address_____Apt Number_____

City _____County _____State _____Zip Code _____

Home Telephone Number_____-_____-_____Work Number _____-_____-_____Cell Number _____-_____-_____

3. FAMILY/HOUSEHOLD INFORMATION

Please provide the number of persons in patient's family/household? _____

Please provide the number of persons who are dependents of patient? _____

Please provide the age of each of patient's dependents in the table below:

Dependent	Age
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

4. FAMILY INCOME AND EMPLOYMENT INFORMATION

Is patient or patient's spouse or partner currently employed? _____Yes _____No

If Yes, provide the following information for all employers:

Employer Name	Address (Street Address, City, State Zip Code)	Telephone

If patient is a minor, are patient's parents or guardians currently employed? _____Yes _____No

If Yes, provide the following information for all employers:

Employer Name	Address (Street Address, City, State Zip Code)	Telephone

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If patient is divorced or separated or was a party to a dissolution proceeding, is patient's former spouse or partner financially responsible for patient's medical care per the dissolution or separation agreement? _____Yes _____No

What is your gross monthly family income (including cases in which a spouse or partner is a guarantor for patient or in which a parent or guardian is a guarantor for a minor patient)? $_____

Sources of gross monthly family income (check all that apply):

____ Wages

____ Self Employment

____ Unemployment Compensation

____ Social Security

____ Social Security Disability

____ Veteran's Pension

____ Veteran's Disability

____ Private Disability

____ Workers' Compensation

____ Temporary Assistance for Needy Families

____ Retirement Income

____ Child Support, Alimony or other Spousal Support

____ Other Income

5. INSURANCE/BENEFIT INFORMATION

Do you or your spouse have access to any type of health insurance coverage? _____Yes _____No

If yes please provide the source (check all that apply):

____ Health Insurance

____ Medicare

____ Medicare Part D

____ Medicare Supplement

____ Medicaid

____ Veterans' benefit

6. MONTHLY EXPENSES

Note that if patient meets the presumptive eligibility criteria, as set forth in that application, or is otherwise presumptively eligible by virtue of the patient's family income, the patient is not required to complete the portion of this application addressing the monthly expense information.

Housing	Utilities	Food	Transportation	Child Care	Loans	Medical Expenses	Other Expenses	Total
$	$	$	$	$	$	$	$	$

of

Patient 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 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 or Applicant Date

of