Northwestern Medicine®

Today's Date _____

FINANCIAL ASSISTANCE APPLICATION

Patient Name _____ MRN _____

You may be able to receive free or discounted care.
Complete this application to help Northwestern Memorial HealthCare (NMHC) determine if you can get:

- Free or discounted services
- Other public programs that can help pay for your health care

If you do not have health insurance: You do not need a Social Security Number to get free or discounted care.
A Social Security Number is required for some public programs, including Medicaid. You are not required to provide a Social Security Number, but doing so will help NMHC determine if you qualify for any public programs.

Complete this form and submit it in person or by mail, email or fax, along with **all** required supporting documents. You must submit a complete application and supporting documents **within 240 days** after you are discharged or get outpatient care.

You acknowledge you tried in good faith to apply for free or discounted care within 240 days after the date of discharge or the date you received outpatient care. You acknowledge you have made a good faith effort to give all information this application requests to help NMHC determine if you qualify for financial assistance.

If you do not have health insurance and meet certain criteria: You do not need to complete this application.

- ☐ You are experiencing homelessness.
- ☐ Patient is deceased, with no spouse/estate.
- ☐ You are unable to make your own decisions (mental incapacitation) and have no one to act on your behalf.
- ☐ You are eligible for Medicaid, but not date of service.

Select any of these programs you are enrolled in.

- ☐ Women, Infants and Children Nutrition Program (WIC)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Illinois Free Lunch and Breakfast Program
- ☐ Illinois Home Energy Assistance Program (LIHEAP)

Your Information			
Name	Social Security Number	Date of Birth	
Home Address	City	State	ZIP Code
Home Phone Number	Cell Phone Number	Email	
Preferred Method of Contact ☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone	☐ I am experiencing homelessness	Annual Household Income	
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow or Widower	Number of People in your Household (as reported on your taxes):		
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed (add last date worked) _____			
Employer Name	Phone Number		
Employer Address	City	State	ZIP Code
Name of health insurance plan your employer offers, including COBRA	☐ Your employer does not offer health insurance.		

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Insurance Coverage		
Are you covered or eligible for any health insurance policy, including: • International/travel health insurance • Health Insurance Marketplace plans • Veterans' benefits • Medicaid • Medicare ☐ Yes ☐ No **If you answered yes, please give the following information:**		
Name of the person who bought the plan (policyholder):	Insurer	Policy Number
Name of the person who bought the plan (policyholder):	Insurer	Policy Number

Spouse, Partner, Parent or Guarantor (When Applicable)			
Relationship ☐ Spouse ☐ Partner ☐ Parent ☐ Guarantor ☐ Other _____			
Name	Social Security Number	Date of Birth	
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed (add last date worked) _____			
Employer Name	Phone Number		
Employer Address	City	State	ZIP Code
Name of health insurance plan the employer offers, including COBRA	☐ The employer does not offer health insurance.		

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Questionnaire	
1. Did you live in Illinois when you received your care?	☐ Yes ☐ No
2. Are you a foreign national (not a U.S. citizen) living in Illinois on a U.S. visa? A. If yes, what type of visa? _____	☐ Yes ☐ No
3. Do you want financial help for care you received in our emergency department?	☐ Yes ☐ No
4. If you are divorced or separated: Is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement?	☐ N/A ☐ Yes ☐ No
5. Was your care related to any of the following? ☐ Accident ☐ Crime ☐ Workplace Injury ☐ Other _____	
6. Have you hired an attorney or are you pursuing a claim for your injury or illness? A. If you answered yes, please provide: _____ Attorney Name _____ Attorney Phone Number	☐ Yes ☐ No
7. Have you already applied for Medicaid? We may require you to. A. If you answered no, please check all that apply: ☐ You are 19 years or younger. ☐ You are 65 years or older. ☐ You are blind. ☐ You are taking medication to manage diabetes, high blood pressure or seizures. ☐ You are disabled, as determined by the Social Security Administration. ☐ You are pregnant. ☐ You have children younger than 19 living with you.	☐ Yes – Waiting for Approval ☐ Yes – Not Eligible ☐ No

ASSETS
1. **Property:** Please give information about any buildings or land you own that **are not the main place you live**. A. What is the value of all buildings and land minus the amount you owe on the property? $ _____ ☐ Not applicable I. Is this property used to make money? ☐ Yes ☐ No B. What is the value of the land (without buildings) minus the amount you owe on the property? $ _____ ☐ Not applicable I. Is this property used to make money? ☐ Yes ☐ No
2. **Bank accounts and investments:** Please list the total amount in each of the following. A. Checking accounts, savings accounts and credit union accounts: $ _____ ☐ Not applicable B. Other investments, such as bonds and stocks. Do **not** include any type of retirement account. $ _____ ☐ Not applicable

By signing, I agree that:
- I will apply for any state, federal or local assistance I may be eligible for to help pay this bill.
- The information in this application is true and correct to the best of my knowledge.
- I understand NMHC may confirm this information.
- NMHC may contact third parties to check the information I provided in this application.

I understand that if I knowingly provided false information, if the application has a significant mistake, or if something significant was left out:
- I will not be eligible for financial help.
- Any financial help granted to me may be reversed.
- I will be responsible for paying the bill.

Time _____ Date _____ Applicant Signature _____

Time _____ Date _____

☐ Spouse ☐ Partner ☐ Parent ☐ Guarantor *(check one)* Signature (when applicable) _____

Please return completed application and any supporting documents to:

Northwestern Memorial HealthCare
Attention: Financial Counseling
675 North Saint Clair Street, Suite 2-110, Chicago, Illinois 60611

Phone: 312.926.6906 or 800.423.0523
Fax: 312.694.0447
finapps@nm.org

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Required Supporting Documents for Financial Assistance

Your application will be delayed or denied if you do not include all of the required document. If you cannot provide a required document, provide a letter explaining why.

Required documents

- A copy of your most recent federal tax return **and** W-2 or IRS Form 4506-T: Request for Transcript of Tax Return.
- **A copy of a valid government-issued photo ID**, such as your driver's license or passport.
- At least **one** of these documents:
  - ☐ A copy of a valid Illinois-issued photo ID or driver's license
  - ☐ Recent utility bill with an Illinois address
  - ☐ A copy of your Illinois voter registration card
  - ☐ Mail addressed to your current address from a government or other credible source
  - ☐ Letter from homeless shelter
- All the documents listed below that apply to you:
  - ☐ Copies of your two most recent unemployment checks or stubs
  - ☐ Copies of your two most recent employer checks or stubs
  - ☐ Copies of your two most recent Social Security checks or stubs
- Your two most recent statements for all checking, savings and credit union accounts.
- Completed and signed application.

Other documents

- If you have not submitted a tax return for last year **or** if your alimony, business, retirement or pension income will be different from last year: Provide the non-wage documents below that apply to you.
  - ☐ Statement of alimony income
  - ☐ Statement of business income
  - ☐ Statement of retirement or pension income
- If you are married or in a civil union: Provide the documents below that apply for your spouse or partner.
  - ☐ Proof of income and non-wage income (as described above)
  - ☐ Federal tax return
  - ☐ W-2 or IRS Form 4506-T: Request for Transcript of Tax Return
  - ☐ Most recent statement for all checking, savings and credit union accounts
- If you are a foreign national (not a U.S. citizen):
  - ☐ Submit a copy of your passport and U.S. visa.