The financial assistance program of the Hospital is a program designed to provide medical care for free or at a reduced cost if the recipient of the care is not able to pay for the services received. This program does not cover services that are provided by medical personnel not considered part of the hospital's medical staff; for example, radiologists or anesthesiologists not employed by the hospital.

Eligibility for this program is based upon your family income and resources, taking family size into account. Additionally, you must apply for and use any private health care coverage or government health care coverage (such as Medicaid and Medicare) available to you.

You must submit the following documents as evidence of your eligibility. If you have other documents that will support your eligibility, you may submit those as well. ***Please do not send originals, as the documents are securely shredded after a decision has been reached.***

- **Pay stubs for the last 3 pay periods**
- **Income tax returns from the previous year**
- **Proof of any other income for the past 3 months (social security, disability, pensions, unemployment)**
- **Bank statements (checking, savings, Certificates of Deposit and/or Money Market)**
- **Outstanding Loans/payment amounts**
- **Unemployment compensation forms approving or denying your claim**
- **Written statements from welfare agencies.**

Once the hospital has received the requested documentation from you, we will make every reasonable effort to make a determination and notify you of our decision within 60 calendar days.

Please return the completed Financial Assistance Application and supporting documentation to the following address.

Edward Hospital and Health Services/Linden Oaks Hospital
801 S Washington Street
Naperville, IL 60540
Attn: Patient Accounts/Financial Assistance Review

Completed application and documents may also be brought to the hospitals Outpatient Registration Area, Booth J.

APPLICATION FOR FINANCIAL ASSISTANCE

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

PATIENT INFORMATION

Patient Name	Date of Birth	Social Security Number

Address	City	State	Zip code

E-mail address	Telephone number	Was patient an Illinois Resident at time services were rendered?
@	( )	YES NO

HOUSEHOLD INFORMATION

Number of persons in the family household	Number of persons who are dependents of the patient.	List all Ages of dependents

EMPLOYMENT INFORMATION

Patient's Employer	Address	Telephone number
		( )
Spouse's Employer	Address	Telephone number
		( )

INCOME

Wages (including Social Security)	$
Self Employment	$
Workers' Compensation	$
Alimony/Child Support	$
Retirement Income	$
Disability	$
Temporary Assistance for Needy Families	$
Other Income:	$

ASSETS

Checking	$
Savings	$
Stocks	$
Certificates of Deposit	$
Mutual funds	$
Automobiles or other vehicles	$
Property	$
Health Savings/Flexible Spending	$

Note: If the patient meets one of the following criteria, the Monthly Expenses table does not need to be completed. Please check all that apply.

- ☐ Homeless
- ☐ Deceased with no estate
- ☐ Mentally incapacitated with no one to act on patient's behalf
- ☐ Recent personal bankruptcy
- ☐ Incarceration in a penal institution
- ☐ Medicaid Eligible, but not on date of service or for non-covered service.

Enrolled in one of the following programs:

- ☐ Women, Infants and Children Nutrition Program (WIC)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Illinois Free Lunch and Breakfast Program
- ☐ Low Income Home Energy Assistance Program (LIHEAP)
- ☐ Receipt of grant assistance for medical workers
- ☐ Enrollment in an organized community-based-program proving access to medical care that assesses and documents limited low-income financial status as a criterion for membership.

MONTHLY EXPENSES	MONTHLY AMOUNT DUE
Housing	$
Utilities	$
Food	$
Transportation	$
Child Care	$
Loans	$
Medical Expenses	$
Other expenses	$

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: