100 N. River Road, Des Plaines, IL 60016

We are sending you this letter along with the attached financial assistance application in response to your request. If you did not submit a request, please disregard this notice.

Dear Patient/Applicant,

Holy Family Medical Center is driven by compassion and dedicated to providing personalized care for all, especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for your healthcare needs.

Please complete the application, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income:

- Two (2) most recent paystubs from employer
- Most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent/Guardian's most recent yearly tax return (if applicant is a dependent listed on their tax form and under the age 25)
- Other income validation documents
- Bank statements from last 3 months
- Receipt of unemployment benefits

If you receive assistance from, or live in a home with, family or friends, please ask them to complete the attached "Letter of Support" form. This will not make them responsible for your medical bills. It simply helps us understand how you are able to meet your living expenses. If you do not receive assistance from family or friends, please remember that your completed application and proof of income must be submitted for us to consider your request. Unfortunately, we cannot process incomplete applications.

Please keep in mind that email communications over the internet are not fully secure. While unlikely, there is a possibility that information you include in an email could be intercepted and read by someone other than the intended recipient. Because your application contains sensitive information, including your Social Security number, we want to protect your privacy and ensure your information remains secure. For this reason, we strongly encourage you not to send the application by email.

If you have any questions about the application process, please contact Holy Family Medical Center Patient Financial Services at 773-990-3289.

Sincerely,
Holy Family Medical Center Patient Financial Services

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Holy Family Medical Center 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 Holy Family Medical Center determine whether you qualify for any public programs. For any application questions marked "optional," your response (or non-response) will not have any impact on the outcome of the application.

Please complete this application and submit it to Holy Family Medical Center by mail, by electronic mail (email), or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your application for up to 240 days following the first billing statement for your care. By submitting this application, you acknowledge that you have made a good faith effort to provide all information request in the application to assist Holy Family Medical Center in determining whether the patient is eligible for financial assistance. If you have any questions on the application process, you may contact Holy Family Medical Center Patient Financial Services with questions or concerns at 773-990-3289.

Mail this application to:	**Email this application to:**
Holy Family Medical Center c/o Patient Financial Services-HBRC 3628 E Imperial Hwy, Suite 104 Lynwood, CA 90262	FinancialAssistance@primehealthcare.com **Fax this application to:** 310-900-8857

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General. The Health Care Bureau's toll-free hotline is 877-305-5145 (TTY 800-964-3013).

Patient Information

Date ___________________________

Account number ____

Name (first and last) ____

Birth date _____________________ Marital status ________________ Phone number _____________________

Address ____

Social Security Number: ***(Optional)*** _____________________________________

Employer ____ Employment status _____________________

Gender Identity ***(Optional)*** Do you think of yourself as:

☐ Male ☐ Female

☐ Transgender man/trans man/female-to-male (FTM)

☐ Transgender woman/trans woman/male-to-female (MTF)

☐ Genderqueer/gender nonconforming neither exclusively male nor female

☐ Additional gender category (or other)

Gender Identity ***(Optional)***
What sex was originally listed on your birth certificate? ☐ Male ☐ Female

Race ***(Optional)***
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Ethnicity ***(Optional)***
☐ Hispanic, Latino/a, or Spanish origin ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin

Preferred Language ***(Optional)***
Is your primary or preferred language a language other than English? ☐ Yes ☐ No
If yes, which language: ____________________

Responsible party's information/legal guardian's information
(If patient is same as responsible party, leave this section blank)

Name (first and last) ____

Birth date ____________________ Marital status _______________ Phone number ____________________

Address ____

Social Security Number: ***(Optional)*** ___________________________________

Employer ____ Employment status ____________________

Responsible party spouse information
(If patient is same as responsible party, fill in spouse information for patient)

Name (first and last) ____

Birth date ____________________ Marital status _______________ Phone number ____________________

Address ____

Social Security Number: ***(Optional)*** ___________________________________

Employer ____ Employment status ____________________

Holy Family Medical Center

100 N. River Road, Des Plaines, IL 60016

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name ____________________________ Birth date ___________ Relationship to responsible party ___________
Name ____________________________ Birth date ___________ Relationship to responsible party ___________
Name ____________________________ Birth date ___________ Relationship to responsible party ___________
Name ____________________________ Birth date ___________ Relationship to responsible party ___________
Name ____________________________ Birth date ___________ Relationship to responsible party ___________

Number of adults and children in household ___________

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income ______________________
Applicant spouse income ______________________
Social security benefits ______________________
Child support received ______________________
Alimony received ____________________________

Monthly living expenses

Patients who are presumptively eligible for financial assistance as described in **Holy Family Medical Center's** Financial Assistance Policy are not required to complete this section.

Mortgage/rent ______________________
Utilities ______________________
Phone (landline) ______________________
Cell phone ______________________
Groceries/food ______________________
Cable/internet/satellite tv ______________________
Car payment ______________________
Childcare ______________________
Child support/alimony ______________________
Doctor/hospital bills ______________________
Car/auto insurance ______________________
Other monthly expenses ______________________

Total monthly expenses ______________________

Assets

Stocks/bonds/investments/CD(s) ______________________
Other real estate/secondary residence ______________________
Boat/RV/motorcycle/recreational vehicle ______________________
Collector automobiles/non-essential automobiles ______________________
Health savings/Flexible Spending Account vehicle ______________________

AUTHORIZATION

I authorize **Holy Family Medical Center** to obtain information from external credit reporting agencies. 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 my medical bills. I understand that this information provided may be verified by **Holy Family Medical Center**, and I authorize **Holy Family Medical Center** 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 bill(s).

Signature of Applicant

____

Date

____

COMMENTS

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Holy Family Medical Center
100 N. River Road, Des Plaines, IL 60016

LETTER OF SUPPORT

Patient medical record number/account number

____

Supporter's name

____

Relationship to patient/applicant

____

Supporter's address

____

To **Holy Family Medical Center**:

This letter is to advise that (patient's name) ____ receives little or no income and I am assisting with his/her living expenses. He/She/They has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of Supporter

____

Date

____