

Application for Financial Assistance Program

We understand that medical expenses are often unplanned and, in the event of financial hardship, we help our patients explore available resources to resolve their medical bills. Northwestern Lake Forest Hospital ensures that all patients receive high-quality care without regard for an individual ability to pay.

Northwestern Lake Forest Hospital offers a variety of financial assistance programs to meet our insured and uninsured patients' needs. Financial assistance programs include free care, discounted care, and extended payment plans. If approved, this program covers medically necessary services provided by Northwestern Lake Forest Hospital and our Emergency Room Physicians. It does not apply to any other fees a patient may incur. To help us determine if you are qualified to receive financial assistance, please **complete, sign and return** this application along with copies of any of the following supporting documentation you have, including:

- Driver's license or other state-issued ID
- Your most recent federal income tax return, schedules and W2s

If you have not filed a tax return please provide us with the following:

- Your three most recent paycheck stubs or other proof of income
- Social Security award letter (income or disability)
- Financial award letter(s) for any student loans or grants
- Unemployment Compensation Benefit Award Letter

Please send the application and all supporting documents to:

Northwestern Lake Forest Hospital
Patient Financial Services
660 North Westmoreland Road
Lake Forest, Illinois 60045-1659

Once your application is received, a determination will be made and a written response will be sent to you within thirty (30) days of receiving your completed application packet. If you have any other questions or need help completing the application, please call us at 847.535.6100.

Application for Financial Assistance Program

Patient Name: _____ Date of Birth: _____ Family Size: _____

Applicant Annual Income: _____ Spouse Annual Income or N/A: _____

PATIENT OR GUARANTOR INFORMATION

Name: _____ Relationship to Patient: _____

Permanent Address: _____ Home Phone: () _____

_____ Cell Phone: () _____

Are you currently employed? Yes No

Full Time Part Time

Employer Name: _____

Occupation: _____

Permanent Address: _____

Telephone: () _____

If you are not employed, have you (or your spouse) been employed within the last 6 months? Yes No

Email Address: _____

Did you receive services through the Emergency Room? Yes No

Are you homeless? Yes No

ASSETS

1. Do you Own Rent your primary residence? What is your monthly payment? _____

If own, what is the approximate current market value: _____

2. Do you own other real estate? Yes No If yes, what is the current market value: _____

3. Do you own an automobile? Yes No If yes, what is the current market value: _____

4. Do you have any bank or brokerage accounts? Yes No

If yes, name(s) of bank/brokerage: _____

Total account balance: _____

5. Do you own any of the following? (check all that apply)

Stocks/Bonds current value: _____

Certificates of Deposit current value: _____

Other Assets current value: _____

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OTHER INSURANCE

1. Are you covered under any health insurance policy, including foreign coverage, Medicaid and Medicare?

Yes No

If yes, please provide the following information:

Policy Holder: _____

Insurer: _____

Policy Number: _____

Policy Holder: _____

Insurer: _____

Policy Number: _____

2. Are you a college student? Yes No

If yes: Full Time Part Time Name of School: _____

Do you have healthcare coverage through student insurance? Yes No

If yes, please provide:

Policy Holder: _____

Insurer: _____

Policy Number: _____

Please include your parents' most recent federal income tax return, schedules and W2s

3. Are you currently approved for Free or Discounted Care at another hospital or community health center?

Yes No If yes, where? _____

AUTHORIZATION AND CONSENT

I hereby authorize the release of the information contained in this application to Northwestern Lake Forest Hospital (NLFH) for the determination of my eligibility status for various financial assistance programs in accordance with each entity's policies and procedures. I authorize NLFH to verify this information as necessary, which may include but is not limited to, obtaining a credit bureau report, employment and/or income verification and appropriate supporting documents.

All information and income documentation provided by me in this application is true, accurate and complete as shown. If it is determined at any time the information I provided is found to be false and or inaccurate, all Free Care grants awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

I also agree to accept payment responsibility for any amount due after any partial Free Care grant may be awarded.

Patient/Guarantor Signature: _____

Date: _____