

# Application for Financial Assistance



As part of our commitment to the community, Northwest Community Hospital (NCH) provides services free or at a reduced rate to individuals with limited financial resources who are uninsured and are unable to access entitlement programs. Individuals needing medically necessary health care services may be eligible for free or reduced rates based on established eligibility criteria.

The initial application must be submitted within sixty (60) days from the date of service. The approval of this application is based upon the applicant and/or patient following through to obtain whatever Medicaid or third party medical insurance coverage (s)he is entitled to receive.

**Patient Account Number(s)**

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Patient Name: \_\_\_\_\_ Home Telephone #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Marital Status – Check (✓) one:  Single/Widowed     Married     Divorced     Separated  
 Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ Driver's License State and #: \_\_\_\_\_

**List all dependents:**

Name	Birthdate	Relationship
1.		
2.		
3.		
4.		
5.		

(If more than five (5) dependents, please attach additional information on a separate piece of paper.)

**Employment:**

Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Length of Employment: \_\_\_\_\_ Position: \_\_\_\_\_ Current Weekly Salary (before deductions): \_\_\_\_\_  
 Are you eligible for insurance through your employer?    Y     N   
 Did you decline taking insurance through your employer?    Y     N

Spouse's Name: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Length of Employment: \_\_\_\_\_ Position: \_\_\_\_\_ Current Weekly Salary (before deductions): \_\_\_\_\_  
 Are you eligible for insurance through your employer?    Y     N   
 Did you decline taking insurance through your employer?    Y     N



**List all Family Income:**

Definition of "family income" includes: Income before taxes, wages, salaries, welfare benefits, Social Security benefits, strike benefits, unemployment benefits, worker's compensation, child support, alimony, dividends, interest, support from parents if parents claim the child on taxes, veteran's benefits, training stipends, military allotments, regular support from family members or other individuals, living or not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, and trusts.

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**List all Assets:**

Definition of "assets" includes: Immediately available cash and investments such as savings and checking account balances as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, real estate except for primary residence, etc.

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**Verification:**

The items on the following list are required in order to determine whether a financial assistance allowance is applicable toward your account(s). Please submit the following:

**At least one of the items marked with an asterisk \* is required. However, supplying only that document could limit the amount of financial assistance awarded. Non-Illinois residents are required to submit documents listed under a – i.**

a) * Copy of most current 1040 income tax return	e) Copy of Social Security check
b) * W-2s, including all applicable schedules	f) Copies of unemployment/disability payments
c) * Copies of last two (2) months pay stubs	g) Copies of last six (6) checking account statements
d) * Written employer verification of income if paid in cash	h) Copies of last six (6) credit union statements
	i) Copies of last six (6) savings / investment account statements for each account

**Do not send original documents.**

***I hereby certify that the information given is true and correct to the best of my knowledge.***

***I recognize Northwest Community Hospital reserves the right to verify all information, and also acknowledge that falsification of any information provided within the application or during the application process will disqualify the patient/guarantor from all financial assistance that has already been provided or that may have been awarded as a result of the application submitted.***

***I authorize Northwest Community Hospital and/or Northwest Community Day Surgery Center to request a credit bureau report(s).***

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Relationship to Patient (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Our address is:** Northwest Community Hospital  
Patient Financial Services / Financial Counselor  
3060 Salt Creek Lane  
Arlington Heights, IL 60005  
847.618.4542