HOSPITAL FINANCIAL ASSISTANCE APPLICATION COVER LETTER

Northwest Community Hospital (NCH) and Day Surgery Center II (DSV) offer a variety of financial assistance programs to meet the needs of our patients. Our programs apply only to NCH and DSV charges. Please be aware you will receive a separate bill from each independent practitioner, or groups of practitioners, for care, treatment, or services provided. The Hospital Financial Assistance Program does not apply to these charges.

In addition to the Hospital Financial Assistance Programs, you may also be eligible for public programs such as Medicaid, Medicare, or AllKids. Applying for such programs may be required prior to applying for a Hospital Financial Assistance Program. NCH and DSV will assist patients with state funded public programs and the enrollment process.

IF YOU ARE UNINSURED, A SOCIAL SECUITY 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.

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help NCH and DSV determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form and submit this application to the hospital in person, by mail or by fax to apply for free or discounted are within 240 days after the hospital provides the first bill for care.

The Hospital Financial Assistance, Discount Programs and Payment Options include:

Program	Available to:	Description	How to Apply
Self-Pay Discount	Uninsured Patients	Offers an automatic discount from charges based upon the NCH Self-Pay Discount Policy.	No application necessary. Contact one of our Self Pay Specialists at *847.618.4747* if you have already received a statement.
Presumptive Eligibility	Uninsured Patients	Predictive model that incorporates criteria determined by the government resulting in a 100% charity care discount.	If possible, complete the Financial Assistance Program Application.
Financial Assistance	Insured Patients	Balances after insurance payments may receive a charity care discount up to 100% based on family size and income according to the Federal Poverty Guidelines. Insured patients are eligible only for the NCH Financial Assistance criteria, NOT the Illinois Hospital Uninsured Patient Discount.	Complete the Financial Assistance Program Application.
Uninsured Financial Assistance	Uninsured Patients	Offers charity or discounted care based on family size and income according to the Federal Poverty Guidelines. Uninsured patients are eligible under the NCH Financial Assistance criteria and the Illinois Hospital Uninsured Patient Discount.	Complete the Financial Assistance Program Application.
Catastrophic Discount	Uninsured & Insured Patients	Limits the Out-of-Pocket costs when medical debts specific to medical care at Northwest Community Hospital exceeds 25% of the patient's family gross income.	Determine if your out-of-pocket expenses exceed 25% of family gross income. If so, complete the Financial Assistance Program Application.
Payment Plan Program	Uninsured & Insured Patients	Assists patients with their financial obligations by establishing payment arrangements.	No application necessary. Contact one of our Self Pay Specialists at *847.618.4747* if you have already received a statement.

We will respond to you within 45 days of receiving the completed application and supporting documents. If you have any questions or need additional assistance, please contact a Financial Counselor at 847.618.4542 or visit http://www.nch.org/patients-visitors/fees-and-bill-payment/patient-financial-assistance to obtain additional information regarding the Hospital Financial Assistance Programs.

Any 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.

https://www.illinoisattorneygeneral.gov/consumers/healthcare.html

Health Care Hotline at 1-877-305-5145 (TTY 1-800-964-3013)

Program Applying for:

- ❑ Uninsured Financial Assistance
- ❑ Insured Financial Assistance
- ❑ Catastrophic Discount
- ❑ Presumptive Eligibility

Hospital Financial Assistance Program Application

NOTE: This application is for Northwest Community Hospital (NCH) and Day Surgery (DSV) charges only. Physician charges may apply in accordance with the policy. Please complete both sides of this form and return the signed form with all required documents.

1. APPLICANT INFORMATION *If the patient is a minor, list parent(s)/guardian(s) as applicant.*				
Name		Home Phone	Cell Phone	
Home Address		City	State	Zip
Social Security #	Marital Status	Date of Birth	Email Address	
Race (optional)	Ethnicity (optional)	Gender (optional)	Preferred Language (optional)	

2. ADDITIONAL FAMILY MEMBERS/DEPENDENTS

Name	Date of Birth	Relationship to Applicant

3. EMPLOYER INFORMATION

Name of Income Recipient	Employer Name & Address	Length of Employment & Position

4. OTHER INCOME INFORMATION

List all other sources of income including dividends, interest, social security benefits, workers' compensation, training stipends, and regular support from family members not living in the same household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends.

Name of Income Recipient	Type of Income	Monthly Income

5. MONTHLY MORTGAGE OR RENT PAYMENT

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******If other person(s) provide primary support for daily living expenses and/or room and board, or you do not have a monthly mortgage or rent payment, please complete the Primary Support Form or provide documentation that mortgage paid in full.

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6. ASSETS

Immediately available cash and investments such as savings and checking account balances. Assets do not include the applicant's primary residence, personal property exempt or any amounts held in a pension or retirement plan. Also include documentation for anyone listed as a family member/dependent. Please list assets and approximate value. Acceptable documentation includes statements from financial institutions or some other third party verification of assets value.

Owner	Type	Approximate Value

7. SIGNATURE

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 reverse, and I will be responsible for the payment of the hospital bill. I will immediately notify NCH if my financial circumstances change.

Applicant Signature	**Date** / /	
Applicant Unable to Sign	**Date** / /	**Relation to Applicant**

PLEASE INCLUDE THE FOLLOWING WITH YOUR SIGNED AND DATED APPLICATION

- ❑ Most recent Federal Income Tax Return signed/dated including all schedules with W-2's and 1099
- ❑ Tax return claiming patient as dependent
- ❑ 2 most recent paycheck stubs (or other proof of income) reflecting 30 days and list year-to-date earnings
- ❑ 3 months of all checking/saving account bank statements all pages
- ❑ Illinois residency verification (Driver's License, recent utility bill, lease agreement, see financial counselor for other forms of verification)
- ❑ Social Security Award Letter
- ❑ Employer Wage Letter if paid in cash
- ❑ Unemployment Compensation Award Letter
- ❑ Notarized Primary Support Form with copy of ID that has address of person signing form
- ❑ Presumptive Eligibility verification (Copy of Link Card, food stamps, WIC program, PADS ID, homeless verification see financial counselor for more information)
- ❑ Self-Employment Verification form
- ❑ Pension Award Letter

RETURN COMPLETED APPLICATION AND DOCUMENTATION TO THE ADDRESS LISTED BELOW. THE APPLICATION AND NCH DOCUMENTS CAN BE FOUND AT http://www.nch.org/patients-visitors/fees-and-bill-payment/patient-financial-assistance

Northwest Community Hospital
Medical Records/Financial Counselors
ATTN: Financial Counseling
800 West Central Road
Arlington Heights, IL 60005
Fax 847-618-4549

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