NCH Patient Services Center
800 West Central Road Arlington Heights, IL 60005
847.618.4542 www.nch.org

HOSPITAL FINANCIAL ASSISTANCE APPLICATION CONSENT AND ACKNOWLEDGEMENT

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 an application in person, by mail, by fax or via your MyChart account to apply for free or discounted are within 240 days after the hospital provides the first bill for care.

RETURN COMPLETED APPLICATION AND DOCUMENTATION TO THE ADDRESS LISTED BELOW, OR COMPLETE THE APPLICATION AND DOCUMENTATION STEPS VIA THE FINANCIAL ASSISTANCE REQUEST PROCESS IN YOUR MYCHART ACCOUNT.
http://www.nch.org/patients-visitors/fees-and-bill-payment/patient-financial-assistance

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**

_____/_____/_____

Northwest Community Hospital
Patient Services Center
ATTN: Financial Counseling
800 West Central Road
Arlington Heights, IL 60005
Fax 847-618-4549

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-billpayment/patient-financial-assistance to obtain additional information regarding the Hospital Financial Assistance Programs.