

La Rabida Children's Hospital

East 65th Street at Lake Michigan
Chicago, IL 60649
P: 773.363.6700



Financial Assistance Application

Patient's Name	.....
Address	.....
Telephone	(.....)..... City State Zip code
Patient Account Number	.....
Date of Service	.....
Amount Due	.....
Responsible Person's Name	.....
Address	..... <i>(If address information is same as patient, indicate same)</i> City State Zip code
Relationship to Patient	.....

Provide health insurance information, if covered

Insurance Company's Name	.....
Address	.....
Telephone	(.....)..... City State Zip code
Name of Subscriber	.....
Group and Policy Numbers	.....
Effective Dates/...../..... -/...../.....

Do you have coverage through the Illinois Department of Healthcare & Family Services (Public Aid) or have you applied for aid including coverage through Kid Care? Yes No

How many family members in the household?

Is any adult member of the family unable to work due to injury or illness? Yes No

If yes, please explain

Identify members of the household who are employed

Name of Employed Members	.....	.....
Occupation	.....	.....
Monthly Income	.....	.....
Number of Years Employed	.....	.....

List names and ages of dependents below

How many dependents are being supported?

Name of Dependent	.....	.....	.....
Date of Birth	.....	.....	.....
Name of Dependent	.....	.....	.....
Date of Birth	.....	.....	.....

(Use a separate sheet to list additional dependents.)

Is the household receiving any money as a result of child support payments, alimony, Social Security income or any other income? Yes No

If "Yes" indicate source of income and monthly dollar amount: \$

List medical or financial problems within the household

Do you expect to receive payment for these services from any other source including accident or liability coverage? Yes No

Proof of income must be provided. Attach most recent income tax return form and/or the most recent 4 weeks of pay stubs. If receiving Social Security benefits or any other income in addition to the above, attach copies.

Responsible Person's Signature DATE/...../.....

Hospital Representative's Signature DATE/...../.....

FOR HOSPITAL USE ONLY

Patient's Name .....	.....	.....
Number in Household	City	State
Annual Income \$	Total Charges \$ .....	.....

Verification of documentation received

Income Tax Form **Pay Stubs** **Other Income Verification**

Has the guarantor cooperated with all requests? Yes No

Does the guarantor meet the Financial Assistance Guidelines? Comments

Approved: Yes No Approved Amount: \$

Patient Accounts Manager DATE/...../.....

VP Admin & CFO DATE/...../.....