OSF HEALTHCARE

www.osfhealthcare.org

OSF HealthCare Financial Assistance Application

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Patient MRN:_____

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION

- ☐ Copies of 2 pay stubs for 30 Days for all income reported
- ☐ Submit a letter describing your financial situation
- ☐ Copies of unemployment statements for 30 days
- ☐ Copies of Social Security Benefits (if applicable)

Filed Federal income taxes? To request a copy of your taxes, please call 1-800-829-1040 (official transcript, no hand written forms)

- ☐ Yes – Please send the most recent Federal income tax returns and supporting schedules
- ☐ No – Please explain why:

I have applied for or will apply for federal or state medical assistance **(Not Required at NHSC Sites)**

☐ Yes (provide tracking # or denial letter) ☐ No–Not a citizen ☐ No–Over income ☐ No–Other reason, why?_____

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)

Other Wages		Misc. Income		Disability Income		Alimony	
Pension		Rental Income		Veterans Benefits		Unemployment	

PATIENT/RESPONSIBLE PARTY **(Not Required at NHSC Sites)** Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated (documentation required)

Name: (First, Middle, Last)	Social Security Number **(Not Required at NHSC Sites)**:	Birth Date: (MM/DD/YYYY)

Patient/Responsible Party Address:

Phone Number:	Employment Status:	How Often Paid:	Are you claimed on another tax return?
	☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	☐ Yes ☐ No If yes, provide tax return of those claiming you.
Household Size (Patient, Spouse & Dependents)	Employer Name and Address		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY) From: To:	Average Gross Monthly Income: (Amount before taxes) $	Monthly SSI/SSDI: $

The following information is requested, but not required

Race: (Not Required)	Ethnicity: (Not Required)	Sex: (Not Required)	Preferred Language: (Not Required)

SPOUSE (if applicable)

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated **(documentation required, except for not at NHSC sites)**

Name: (First, Middle, Last)	Social Security Number **(Not Required at NHSC Sites)**:	Birth Date: (MM/DD/YYYY)

Phone Number:	Employment Status:	How Often Paid:	Are you claimed on another tax return?
	☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	☐ Yes ☐ No If yes, provide tax return of those claiming you.
Household Size: (Patient, Spouse & Dependents)	Employer Name and Address:		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY) From: To:	Average Gross Monthly Income: (Amount before taxes) $	Monthly SSI/SSDI: $

The following information is requested, but not required

Race: (Not Required)	Ethnicity: (Not Required)	Sex: (Not Required)	Preferred Language: (Not Required)

DEPENDENTS under age of 18 (If more than 3 dependents use a separate page)

Full Name	Relationship	Birth Date (MM/DD/YYYY)	Claimed as a Dependent on Taxes	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No

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 **(not required for NHSC sites)**. 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 reversed, and I will be responsible for the payment of the hospital bill.

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED

Patient/Responsible Party Signature(s)	Date

Dear Valued Patient,

We understand that some of our patients need help to pay for their treatment and eligible medical bills.

The information in this application will help us determine if you qualify for any type of financial assistance.

If you have questions or concerns about our financial assistance application, you may call us at (800) 421-5700 or (309) 683-6750. Complaints or concerns with the uninsured patient discount application process or our financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 1-877-305-5145 (TTY 1-800-964-3013).

Thank you for trusting OSF HealthCare for your health and wellness needs. It's our privilege to serve you with the greatest care and love.

OSF HEALTHCARE

www.osfhealthcare.org

Please complete this application and return all requested documentation to OSF HealthCare

OSF HealthCare Patient Financial Services (Illinois and Michigan)	P.O. Box 1712 Peoria, IL 61656-1701 (800) 421-5700 or (309) 683-6750 Fax (309) 308-3963
OSF Home Infusion Pharmacy OSF Home Medical Equipment	2265 W. Altorfer Road Peoria, IL 61615-1807 Home Infusion Pharmacy: (800) 446-3009 Home Medical Equipment: (877) 795-0416

Please return your completed application within 240 days of your first billing statement in one of three ways:

- Submit your application through your OSF MyChart account. (If you do not have an OSF MyChart account, call our office for helping setting one up.)
- Visit **osfhealthcare.org/billing**, and look for "financial assistance." You can complete the application and upload the required documents on this page.
- Print and fill out your application on paper and send it with copies of your documents by mail, fax, or by dropping them off at any OSF facility.

You will need the following documents to apply for financial assistance.

- Copy of most recent tax return
- Copy of most recent W-2 and 1099 forms
- Copies of 2 most recent pay stubs
- Written income verification from employer if paid in cash
- One other reasonable form of third party income verification deemed acceptable by OSF HealthCare.

Important:

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help OSF HealthCare determine if you can receive free or discounted services or other public programs that can help pay for your health care.

IF YOU ARE UNINSURED, A SOCIAL SECURITY 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.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

If patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the application's section on monthly expenses.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. OSF HealthCare cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. OSF HealthCare postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

OSF HEALTHCARE FINANCIAL ASSISTANCE APPLICATION