WEISS
MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions:

As part of its commitment to serve the community, Weiss Memorial Hospital elects to provide financial assistance to individuals who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a person qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

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.

Please provide the information requested and mail to the following address:

Weiss Memorial Hospital
c/o Business Office
6804 W. Windsor, 1st FL
Berwyn, IL 60402

***Income Verification*:**

IN ORDER TO CONSIDER YOUR REQUEST FOR FINANCIAL ASSISTANCE, VERIFICATION OF INCOME IS REQUIRED. PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

- Governmental Assistance, Social Security, Workers Compensation, or Unemployment Compensation Determination Letter
- Income Tax Return for previous year

PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:

- IRS Form W-2, Wage and Earnings Statement for all household earnings
- Last 2 pay check stubs for all household earnings
- Bank Statement that contains income information

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED**. Please return the application and verification of income within 7 days to the above address.

If a 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.

Notification of Determination:
We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

Physician Services:
The physicians providing services at this Hospital are not employees of Weiss Memorial Hospital. You will receive separate bills from your private physician and from other physicians whose services you required (pathologist, radiologist, surgeon, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office.

For assistance in completing this application, please contact Weiss Memorial Hospital [Customer Service] at (708) 783-3125 or Toll Free: (800) 290-5090, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

GRNTOR #: _____

HOSP CODE: _____

PATIENT INFORMATION/DATOS DEL PACIENTE

Patient Name/Nombre del paciente	Account Balance/Saldo de la cuenta	Patient Number/Número de paciente	Date of Birth/Fecha de nacimiento
Admission Date/Fecha de admisión	Discharge Date/Fecha de alta	Social Security No/No. de Seguridad Social	Marital Status/Estado civil
Home Address/Domicilio particular			
City/Ciudad		State/Estado	Zip/Código postal
Name of Medical Provider/Nombre del proveedor médico		Beginning Coverage Date/Fecha de inicio de cobertura	
Name of Doctor/Nombre del médico			
Employer Name/Nombre del empleador		Occupation/Ocupación	Telephone/Teléfono

GUARANTOR INFORMATION/DATOS DEL AVAL

Name/Nombre		Social Security No/No. de Seguridad Social	Age/Edad
Realationship to Applicant/ Relación con el solicitante	Address/Domicilio		Telephone/Teléfono
City/Ciudad		State/Estado	Zip/Código postal
Employer/Empleador		Employer Phone/Teléfono del empleador	Occupation/Ocupación
Address/Domicilio			
City/Ciudad		State/Estado	ZIP/Código postal

FINANCIAL INFORMATION/DATOS FINANCIEROS

Total Monthly Income/Ingreso mensual total	No. of Dependents/ No. de dependientes	Residence(Own/Rent)/ Residencia (propia/renta)	Car (Model/Year)/Vehículo (modelo/año)

RESOURCES/RECURSOS

Name of Bank/Nombre del banco	Checking Account/Cuenta de cheques	Savings Account/Cuenta de ahorros
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage/ Payment/ Renta/hipoteca/pago	Water Bill/Cuenta de agua	Gas Bill/Cuenta de gas	Phone Bill/Cuenta de teléfono
$	$	$	$
Electric Bill/Cuenta de electricidad	Car Payment/Pago de vehículo	Insurance Premium/Prima de seguro	Other Bills/Otras cuentas
$	$	$	$

HOUSEHOLD COMPOSITION/COMPOSICIÓN DE LA UNIDAD FAMILIAR

Name/Nombre	Relationship/Relación	Date of Birth/Fecha de nacimiento	Social Security No./ No. de Seguridad Social

If unable to provide requested documents, please explain below/

Si no puede proporcionar los documentos solicitados, explique a continuación

COMMENTS/COMENTARIOS:

AFFIDAVIT/DECLARACION

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change of address. I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches. I understand the county is required by law to keep any information I provide confidential. I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.	Declaro bajo pena de perjurio que las respuestas que proporcioné son verídicas y correctas hasta donde tengo conocimiento. Me comprometo a notificar al proveedor del servicio dentro de un plazo de diez (10) días si hay algún cambio en mi ingreso, propiedad, gastos (o en los de las personas a cuyo nombre actúo), o en la unidad familiar de la persona o cualquier cambio de domicilio. Entiendo que quizá se me pida que compruebe mis declaraciones y que mis declaraciones de elegibilidad estarán sujetas a verificación mediante contacto con mi empleador, verificación de crédito bancario y búsquedas de propiedades. Entiendo que el condado está obligado por ley a mantener confidencial toda la información que yo proporcione. Acepto además que a cambio de recibir servicios médicos como resultado de un accidente o una lesión, debo reembolsar al condado utlizando fondos de la compensación obtenida del litigio o acuerdo económico derivado de dicha acción.

_____ _____

Signature/Firma Date/Fecha

For Hospital Use Only/Exclusivamente para uso del hospital

Facility/Centro: _____ **Accepted/Aceptado:** _____ **Denied/Denegado:** _____

COMMENTS/COMENTARIOS:

_____ _____

Signature Approval/Firma de aprobación **Date/Fecha**