CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

For Hospital and Professional services provided by facilities and physicians of Loyola Medicine

LOYOLA
MEDICINE

Thank you for selecting Loyola Medicine as your health care provider. Please complete the enclosed application and return to the address below to complete the evaluation of your financial assistance.

Please contact our Customer Service Center at 708-216-5014 option #5 Monday through Friday between 8:00 am -5:00 pm CST if you have questions on the application or regarding your application status.

Mail: Loyola University Health System, Patient Financial Services Department
Two Westbrook Corporate Center, 6th Floor Westchester, Illinois 60154

Fax #: 708-216-5359 **Email address**: LOY-FinancialAssist@lumc.edu
If you would like to meet with a Benefit Advocate in person or drop off your application, please visit:

Loyola University Medical Center 2160 South 1st Ave Suite/Room 1911 Maywood, IL 60153	Gottlieb Memorial Hospital 701 W. North Ave Door 4 Entrance Melrose Park, IL 60171	MacNeal Hospital 3249 S Oak Park Avenue Berwyn, IL 60402 1st Floor

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Required Verifications

☐ Past One month Proof of Gross Income

☐ Past Two months Complete Bank Statements for all bank accounts, with all pages included. (Explanation for recurring deposits)

☐ Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)

Provide the following, If applicable

☐ Recent W2 for Seasonal Income ☐ Unemployment Benefit/ Denial letter ☐ Child Support Income /Alimony

☐ No Income – Complete Letter of Financial Support portion of the application

Patient Information

Patient Name		Date of Birth	
Social Security/EIN Number (optional)	Mobile Phone	Other Phone	
Mailing Address	City	State	Zip code
Email Address	What state are you a resident?		

Marital status (Optional) ☐ Single ☐ Married ☐ Divorced ☐ Other ______________

Do you file a Federal Tax Return? ☐ Yes ☐ No
If no, why?

Can you be claimed as dependent on someone else's tax return? ☐ Yes ☐ No

Did you or your dependents have health insurance coverage at the time of service? ☐ Yes ☐ No (Provide Insurance card copy)

Are you a documented resident of the United States? (Optional) ☐ Yes ☐ No ☐ Prefer Not to Answer

Household Members, including yourself based on your recent Tax Returns	Date of Birth	Relationship to Patient	Claimed on Tax Return (Yes/No)

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Income Verification for all household members					
Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)	Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)
Wages			Worker's Compensation		
Social Security / Disability			Unemployment		
Pension			Child Support / Alimony		
Self-Employment			Rental Land Income		
Public Assistance			Other		

Letter of Financial Support - Should only be completed by the person providing support

☐ I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.

☒ By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at

____
(Phone Number)

Name of person providing support	**Relationship to Patient**
Signature of person providing support	**Date**

Verification of Income and Identification

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.

Signature of Patient: ____Date: ___________

Or Signature of Legal Guardian (If Applicable): __________________________ Date: ___________

Relationship to Patient: ____ Date: ___________

Please mail your application, fax at 708-216-5359 or e-mail LOY-FinancialAssist@LUMC.EDU If you have any questions, please contact our Customer Service Center at 708-216-5014 Option #5 Monday through Friday 8 a.m. - 5 p.m. CST

Concerns or complaints with the financial assistance application process or uninsured discount may be reported to the Healthcare Bureau of the Illinois Attorney General 1-877-305-5145 / https:illinoisattorneygeneral.gov/consumers/hcform.pdf