NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

Financial Assistance Application

Patient Name:_____

Acct #:_____

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Norwegian American Hospital (NAH) determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

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 and will help the hospital determine whether you qualify for any public programs. Please complete this form and submit it in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 240 days following the date of discharge or receipt of outpatient care. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist NAH in determining whether the patient is eligible for financial assistance.

IF YOU ARE UNINSURED AND MEET SPECIFIC PRESUMPTIVE ELIGIBILITY CRITERIA, YOU ARE NOT REQUIRED TO COMPLETE THIS APPLICATION.

- ☐ Homelessness
- ☐ Deceased with no estate
- ☐ Mental incapacitation with no one to act on patient's behalf
- ☐ Medicaid eligibility, but no date of service

APPLICANT

Applicant Name		Social Security #	Date of Birth
Home Address	City	State	Zip
Home Phone Number	Cell Phone Number	Email Address	
Preferred Method of Contact ☐ US Mail ☐ Email ☐ Home Phone ☐ Cell Phone ☐ I am homeless			Annual Household Income
Applicant's Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow			# of Individuals in your Household (as reported on your taxes)
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed – Last date worked: _____			
Employer Name			Phone Number
Employer Address	City	State	Zip
Name of Health Insurance plan offered by employer (Including COBRA)			☐ Health Insurance not provided

SPOUSE/PARTNER/PARENT/GUARANTOR (when applicable)

Relationship ☐ Spouse ☐ Partner ☐ Parent ☐ Guarantor ☐ Other: _____		
Name	Social Security #	Date of Birth
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed – Last date worked: _____		
Employer Name		Phone Number
Employer Address	City	State	Zip
Name of Health Insurance plan offered by employer (Including COBRA)		☐ Health Insurance not provided

INSURANCE COVERAGE

1. Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefits, Medicaid and Medicare? ☐ Yes ☐ No

   a. If Yes, please provide the following information:

Policy Holder	Insurer	Policy Number
Policy Holder	Insurer	Policy Number

Patient Name:_____
Acct #:_____

QUESTIONNAIRE	
1. Were you an Illinois resident when you received your care?	□ Yes □ No
2. Are you a foreign national residing in Illinois on a U.S. Visa? a. If yes, what type of Visa? _____	□ Yes □ No
3. Are you seeking financial assistance for care received in our emergency room?	□ Yes □ No
4. If you are divorced or separated, is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement?	□ N/A □ Yes □ No
5. Is the treatment provided related to any of the following? □ Accident □ Crime □ Workplace Injury □ Other: _____	
6. Have you hired an attorney or are you pursuing a claim for your injury or illness?	□ Yes □ No
7. Have you already applied for Medicaid? *(we may require that you do so)* □Yes-Awaiting Approval □ Yes-Not Eligible □ No a. If no, please check all of the below that apply: □ You are 19 years or younger □ You are 65 years or older □ You are blind □ You are taking medication to control diabetes, high blood pressure, or seizures □ You are disabled as determined by the Social Security Administration □ You have children under the age of 19 living with you	

ASSETS	
1. **Property**. Please provide information regarding any property *(buildings and/or land)* that you own **other than your primary residence.** a. What is the value of all buildings and land minus the amount owed on the property?	$_____ □ N/A
i. Is the property used as income? □ Yes □ No	
b. What is the value of the land *(without buildings)* minus the amount owed on the property?	$_____ □ N/A
i. Is the property used as income? □ Yes □ No	
2. **Bank Accounts/Investments.** Please list the total current balance for each of the following. a. Checking/Savings/Credit Union Accounts:	$_____ □ N/A
b. Other Investments *(bonds, stocks, etc. **excluding** IRA and/or retirement accounts)*:	$_____ □ N/A

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 NAH, and I authorize NAH 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, or if the application otherwise contains a material error or omission, I will be ineligible for financial assistance, and any financial assistance granted to me may be reversed and I will be responsible for the payment of the bill.

_____ _____
Applicant Signature Spouse/Partner/Parent/Guarantor Signature (when applicable)

_____ _____
Date Date

Please return complete application and supporting documents to:
Norwegian American Hospital
Attn: Registration / Financial Counselor (ZB)
1044 N. Francisco Ave.
Chicago, IL 60622
Phone (773) 292-8369 | Fax (773) 278-8826

Financial Assistance Required Supporting Documents

Please provide the documents requested below. Your application will be delayed or denied in the event that any of the required documents are not included. If you cannot provide document, please provide letter of explanation.

Required:

- Tax documents: Provide your most recent federal tax return and W-2 or IRS Form 4506-T; Request for Transcript of Tax Return.
- Valid Government-Issued Photo ID:
  - Driver's license, passport, etc.
- Proof of Illinois Residency: Provide at least one of the following documents.
  - Valid state-issued photo ID or driver's license
  - Recent utility bill with an Illinois address
  - IL Voter Registration card
  - Current mail addressed to application from a government or other credible source
  - Letter from homeless shelter
- Proof of Income: Provide all applicable document listed below.
  - Copies of your two most recent unemployment checks or stubs
  - Copies of your two most recent employer checks or stubs
  - Copies of your two most recent Social Security checks or stubs
- Proof of assets: Provide you most recent statement for all checking, savings and credit union accounts
- Completed and signed application

Supplemental/Other:

- Proof of Non-Wage Income: Provide the following applicable documents, only if you have not submitted a tax return for the previous calendar year or if any of the following income sources will vary between this calendar year and the previous calendar year
  - Statement of alimony income
  - Statement of business income
  - Statement of retirement or pension income
- If Married or in a Civil Union: Provide the following applicable documents regarding your spouse/partner
  - Proof of income and non-wage income (as described above)
  - Federal tax return and W-2 or IRS Form 4506-T: Request for Transcript of Tax Return
  - Most recent statement for all checking, savings and credent union accounts
- Supplemental/Other (if applicable):
  - Health insurance card (please copy front and back)
  - Medicaid approval/denial letter
  - Letter of support (i.e. if your living expenses are being paid by another party)