



Alexian Assistance Application

*** Application must be returned within 30 days of Assistance request ***

Return to: Alexian Brothers Hospital Network - PFS
Attn: Assistance Department
3040 Salt Creek Lane
Arlington Heights, IL 60005

In order to provide the greatest assistance benefit, all documents are required.

Below is a list of important information that you will need to know regarding your application for financial assistance.

All verification documents must be submitted within 30 days of the date assistance is requested. If the verification documents are not received in our offices during this 30 day period, we will assume you have the ability to make payment and request that you please contact our Patient Financial Services Department to establish payment arrangements for your hospital bills.

IMPORTANT INFORMATION

Eligibility will be determined considering family size and income and uses a calculation based on current Federal Poverty Guidelines as defined in the Federal Register.

A brief description outlining any special circumstances, which would allow us to more fully understand your financial situation, can be included. These special circumstances may be considered in the final determination of assistance.

PROOF OF INCOME REQUIRED: In order to establish your annual gross income, the following documentation is required.

- ***If any of the required documents are unavailable, please include a letter explaining why you cannot send copies for consideration in the final determination for assistance.***
- Copy of Guarantor's government issued ID. For example - any of the following: Driver's license, Passport, Visa, Birth certificate, International ID
- Last four (4) pay stubs, business ledger, (if self employed,) **proof** of child support, unemployment stubs, Social Security annual award letter, 1099, or income verification from employer.
- Copy of your most recent complete Federal tax return.
- Copy of your most recent W2 or 1099 forms.
- Last three months of complete bank statements, (checking and savings.)
- Signed room and board letter, if you depend on someone else to help you meet all or part of your daily living expenses.

QUESTIONS?

Please feel free to call us at 866/690-3370.

Or email your questions to - AlexianAssistance@alexian.net

ALEXIAN ASSISTANCE APPLICATION

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR ALEXIAN ASSISTANCE

PATIENT NAME: _____

ACCOUNT NUMBER(S) _____

RESPONSIBLE PARTY/GUARANTOR NAME: _____

I understand that the information, which I will submit concerning my annual income and family size, is subject to verification.

Last Name First Name M.I. Telephone No.

Street Address City/State Zip Code

Guarantor Social Security Number _____

Name and Address of Guarantor's Employer _____

Name and Address of Spouse's Employer _____

If unemployed, what was last date worked? _____

Did you have insurance coverage with former employer? _____

If unemployed, please describe on reverse side how you meet your daily living expenses.

Please list all family member(s) who live with you

Name Age Relationship

ALEXIAN ASSISTANCE APPLICATION

FINANCIAL DISCLOSURE FORM

Patient Name: _____

Account Number (s) _____

Responsible Person /Guarantor Name: _____

List All Sources Of Your Monthly Gross Income:

Responsible Party's Salary Before Deductions \$ _____

Pension \$ _____

Spouse's Salary Before Deductions \$ _____

Pension \$ _____

Social Security \$ _____

Unemployment \$ _____

Child Support \$ _____

Investment Income \$ _____

Checking \$ _____ Savings \$ _____

Property Value \$ _____

Liquid Assets (Stocks/Bonds/ Ira's/ CD) \$ _____

Other \$ _____ Please Describe: _____

MONTHLY EXPENSES:

Rent/Mortgage/Room & Board \$ _____

Medical Insurance \$ _____ Monthly Medical Expenses \$ _____

Loans \$ _____ Other \$ _____

Total Monthly Expenses \$ _____

I hereby state that the information provided in this document is true and accurate to the best of my knowledge.

Print Name:

Signature

Date

ALEXIAN ASSISTANCE APPLICATION

ROOM AND BOARD STATEMENT

Required only if patient depends on someone else to help meet all or part of daily living expenses

*** To be completed by the person providing assistance to the patient and/ or the patient's family. ***

Date: _____

Patient Name: _____

Account Number (s): _____

Your Name: _____

Your Address: _____

Your Phone: _____

Your Relationship to Patient: _____

Please specify what you provide for the patient.

To Whom It May Concern:

I have provided –

- Room and Board (lodging and food)
- Transportation Expenses, car loan, car insurance, gas, etc.
- Medication
- Clothing
- Credit Card payments
- School Expenses
- Other, Please Describe: _____

to (Patient)_____

for the past _____.

I can continue to provide room and board for the above named person but am unable to contribute toward his/her other medical expenses.

Signature

Date