Marianjoy
Rehabilitation Hospital
part of Northwestern Medicine®

Application for Community Assistance

PLEASE READ FIRST

Important: ***YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:*** Completing this application will help Marianjoy Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

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.

Marianjoy will use the information you provide to determine if you are eligible for coverage through a number of community programs. Therefore it is important that you fill out this application as fully and as accurately as possible. These programs may include;

- Medicare and/ or Medicaid
- Subsidies on the Health Insurance Exchange
- Special Purpose funds or grants for underserved patients or
- Community based program eligibility

Presumptive Eligibility

The Fair Billing Act defines "presumptive eligibility" as eligibility for hospital financial assistance determined by reference to criteria demonstrating financial need on the part of the patient, and "presumptive eligibility criteria" as the categories identified as demonstrating financial need on the part of a patient used by the hospital in the implementation of presumptive eligibility.

Patient demonstrates one or more of the following will automatically:

- Homelessness
- Deceased with no estate
- Mental incapacitation with no representative
- Medicaid eligible but not on the date-of-service or for non-covered services
- Enrollment in a program for low-income individuals with eligibility criteria< 200% Federal Poverty Level such as:
    - IC, SNAP, Illinois Free Breakfast/Lunch, Low Income Home Energy Assistance Program, or a community-based medical assistance program with low-income criteria; or receives grant assistance for medical services

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Marianjoy Rehabilitation Hospital	**Rehabilitation Medicine Clinic**
Phone:630-909-7370	Phone:630-909-7350
Fax: 630-909-7371	Fax: 630-909-7351
Email: mjmrhassistance@Marianjoy.org	Email: rmcassistance@Marianjoy.org

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COMMUNITY CARE FINANCIAL APPLICATION

Date _____ Account Number(s) _____ Patient Name _____

Date of Birth _____Hospital_____ Email Address _____

Patient Address ;

_____

Primary Contact#. _____ SSN (Optional) _____

Marital Status: ____ single ____ married ____ widowed ____ divorced ____ separated

Spouse Name: _____ Number of persons in patient's family/household _____

Number of dependents _____Age of dependents _____

Patient Status (check all that apply) : Homeless ____ Mental incapacitation ____ Medicaid eligible ____ Deceased with no estate _____Resident of Illinois ____ Accident or Crime Victim ____

Are you enrolled in any of the following programs; Woman, Infants and Children Nutrition Program (WIC) ____, Supplemental Assistance Program (SNAP) ____, Illinois Free Lunch and Breakfast Program ____, Low Income Home Energy Assistance Program (LIHEAP) ____, Enrolled in an organized community-based program providing access to medical care that assesses and document limited low-income financial status as criteria _____, Receive grant assistance for medical services _____.

PLEASE READ CAREFULLY! In order for us to process your application for assistance, proof of income and residency must be attached in order to assess eligibility in government programs. **Please note**: Any blank spaces may disqualify or delay processing of your application. **Complete this form in ink**.

Please attach the following Requirements:

☐ Pay Stub ☐ Latest Tax Return _____ ☐ Government Grant Check ☐ Picture I.D.

☐ Copy of Utility Bill ☐ Property tax bill (if home owner) ☐ Mortgage statement (if home owner)

For questions, call _____ at _____ Return by _____

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED!):
Are you presently employed? ☐ Yes ☐ No Are you self-employed? ☐ Yes ☐ No

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Patient or Parent (Only if patient under 18 yrs of age)	Spouse or Parent (Only if under 18 yrs old)
Present or Last Employer	
Street Address Telephone #	
City State Zip	City State Zip
Monthly net income	Monthly net income
Employment Dates From: _____ To: _____ (Require previous employment information if short term)	Employment Dates From: _____ To: _____ (Require previous employment information if short term)

IF HOUSEHOLD INCOME IS AT OR BELOW THE FEDERAL PROVERTY LEVEL, YOU MAY NOT NEED TO COMPLETE THE REST OF THE APPLICATION

OTHER SOURCES OF INCOME (check type and list amount):

- ☐ Alimony / Child Support _____
- ☐ Social Security _____
- ☐ Veterans Pension _____
- ☐ Unemployment Compensation _____
- ☐ School Grants _____
- ☐ Pension Annuity _____
- ☐ Workmen's Compensation _____
- ☐ Rental Income _____
- ☐ Other (specify) _____

Home Owner	Other Property
Location:	Location:
Assessed taxable value:	Assessed taxable value:
Mortgage Due:	Mortgage Due:

CAR INFORMATION

Make and Year	Model	Lien Holder (if other than applicant)	Value	Loan Balance	Monthly Payment

APPLICANT ASSET DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Checking				
Savings				
Cash on Hand				
Income Property				

APPLICANT LIABILITIES DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Mortgage				
Car Loan				
Credit Cards				
Other				

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I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. 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 THE HOSPITAL, AND I AUTHORIZE THE HOSPITAL TO CONTACT THIRD PARTIES TO VERIFIY 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 OR PHYSICIAN BILL

I authorize the release of information to Marianjoy, Inc. for verification of employment, financial and other information contained herein. Also, I acknowledge that I have made a good faith effort to provide all information requested in the application to assist the hospital in determining whether I/ the patient is eligible for financial assistance.

_____ _____
Signature of Patient / Guarantor / Spouse Date

_____ _____
Admissions/PFS Representative Date

OFFICE USE ONLY

Recommendations: _____

Monthly Payment: $ _____ First Payment Due: _____

Approved ☐ Declined ☐

_____
Comments Date

_____ _____
Director Signature V.P. Signature