Shriners Hospitals for Children®

Chicago Charity Care & Transportation and Housing Assistance Application

Shriners Hospitals for Children® is committed to providing care to children with neuromusculoskeletal conditions, burn injuries and certain other special healthcare needs regardless of the patients, their family members, or their guardians' ability to pay. We are asking that you help us fulfill our financial responsibilities so we can accurately document patients who qualify for charity care and transportation assistance.

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Shriners Hospitals for Children 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.

Please complete this form and submit it to the hospital in person, by mail, 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.

Please Answer Each Question

The need for charity care & transportation and housing assistance may be reevaluated at each subsequent time of services if the last financial application relevant to the eligibility of the patient for charity care & transportation assistance is over 12 months old or the household's financial situation changes.

Child's Name_____ **Date of Birth** ___/____/_____

Child's Home Address_____ **City/State/Zip**_____

Social Security Number _____

Parent/Guardian Information:

Name_____ **Relationship to child**_____

Home Address_____ **City/State/Zip**_____

Social Security Number_____ **Primary Phone Number (_____)**_____

FOR HOSPITAL USE ONLY:

MR # or FIN # _____

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Total number of dependent family members living at home (include self) _____

Number of children (ages 0 – 21), included in the above number, living at home _____

Medicaid Application

Please check the appropriate statement boxes below: Attach copies of Medicaid notices including all attachments to the notices.

I/We ☐have / ☐have not applied for Medicaid to cover these services. Please explain reason_____

_____

I/We ☐have / ☐have not been rejected by Medicaid. Reason for reject (please include a copy)

_____

_____

I/We ☐have / ☐have not been rejected by CHIP (Children's Health Insurance Program)

_____

_____

I/We received an approval from Medicaid, but with a monthly spend down rate of $_____

Check the box and provide documentation, if any of the following circumstances apply:

- ☐ State-funded prescription programs;
- ☐ Homeless or received care from a homeless clinic;
- ☐ Participation in Women, Infants and Children programs (WIC);
- ☐ Food stamp eligibility;
- ☐ Free/reduced/discounted school lunch program eligibility;
- ☐ Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
- ☐ Low income/subsidized housing is provided as a valid address; and
- ☐ Parent is deceased with no known estate.

Please note, if the patient meets the presumptive eligibility criteria as defined in Illinois Regulations or because of the patient's family income, the patient is not required to provide monthly expense information or estimated expense figures.

Household Income (Monthly)

Wages

a) **Total wages of Patient/Responsible Person** _____(attach a copy of paycheck stub)

FOR HOSPITAL USE ONLY:

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b) **Employer Name** _____
c) **Employer Address** _____
d) **Spouse's Name** _____
e) **Total Wages of Spouse** _____ (attach a copy of paycheck stub)
f) **Spouse's Employer Name** _____
g) **Employer Address** _____

Other Income

a) **Disability Payments** _____
b) **Alimony/Child Support** _____
c) **Retirement Benefits** _____
d) **Investment Income** _____
e) **Unemployment Compensation** _____

I acknowledge that I have made a good faith effort to provide all information requested in this application to assist the hospital in determining whether the patient is eligible for financial assistance. 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 the hospital and I authorize the hospital 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, 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 bill.

Complaints or concerns with the uninsured patient discount application process, or hospital financial assistance process, may be reported to the Health Care Bureau of the Illinois Attorney General.

The website and phone number are https://illinoisattorneygeneral.gov/consumers/hcform.pdf and 1-877-305-5145.

_____
Printed Name

_____ _____
Signature Date

FOR HOSPITAL USE ONLY:

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Please be sure to enclose all requested income information before submitting your application. Incomplete or fraudulent applications will be denied.

- ☐ Wage/Income statements for the past 90 days
- ☐ Complete prior year's tax return
- ☐ Copy of insurance/Medicaid denial notices
- ☐ Social Security determination notices

FOR HOSPITAL USE ONLY:

MR # or FIN # _____