Application for Shirley Ryan AbilityLab Financial Assistance Program

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Shirley Ryan AbilityLab 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 Shirley Ryan AbilityLab.

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, or by fax to apply for free or discounted care within 60 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 the hospital in determining whether the patient is eligible for financial assistance.

PATIENT CERTIFICATION

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.

Patient (or Applicant) Signature: _____

Patient (or Applicant) Name: _____

Date: _____

Please call **(312) 238-6039** if you have any questions regarding this application. Return your completed application to:

By mail or in person:
Shirley Ryan AbilityLab
Patient Financial Services Department
Financial Assistance Program
355 E. Erie St.
Chicago, IL 60611

By fax:
(312) 238-7569

Patient Information

Patient Name: _____ Patient SSN: _____

Patient Date of Birth: _____ Guarantor Name: _____

Patient Address: Guarantor Address:

_____ _____

_____ _____

_____ _____

Patient Phone Number: _____ Guarantor Phone Number: _____

Patient Household Information

Please provide information for all other members of the patient's household (exclude patient or guarantor information that has been provided above):

Number of persons in the patient's family or household: _____

Number of persons who are dependents of the patient: _____

Ages of each patient's dependents: _____

Circle the person or people who are currently employed: Patient Patient's Spouse/Partner

Patient's parents or guardians (if patient is a minor)

Insurance Information

Mark ***X*** below if the patient is covered under or is a beneficiary of any of the following health insurance programs:

___ Health insurance ___ Medicare ___ Medicare Part D ____ Medicare Supplement

___ Medicaid ____ Veterans' benefits ____ Other ____ Uninsured

Patient Residence Identification

Provide a copy of one of the following documents, to show the patient resides in Illinois:

- A valid Illinois state issued identification card or drivers license;
- A recent residential utility bill;
- An apartment lease;
- A vehicle registration card;
- A voter registration card;
- Mail addressed to the patient at an Illinois address by government entity or other credible source;
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency;
- A letter from a homeless shelter, transitional housing, or similar facility confirming that the patient lives there;
- The patient's most recent tax return;
- The patient's most recent W-2 form and any corresponding 1099 forms; or
- The patient's two most recent pay stubs, if the pay stubs list the patient's home address.

Presumptive Eligibility Criteria. The information you provide on this page will help Shirley Ryan AbilityLab determine if you are presumptively eligible to receive financial assistance. If you meet more than one criteria, you only need to provide supporting documentation for one of the criteria you meet.

Criteria	Circle Yes/No	Include This Supporting Information With Your Application
Women, Infants and Children Nutrition Program (WIC) Enrollment	Yes / No	A copy of any document, such as a letter, that shows the patient is receiving such assistance.
Supplemental Nutrition Assistance Program (SNAP) Enrollment	Yes / No	
Illinois Free Lunch and Breakfast Program Enrollment	Yes / No	
Low Income Home Energy Assistance Program (LIHEAP) Enrollment	Yes / No	
Receipt of grant assistance for medical services	Yes / No	
Medicaid eligible, but not on date of service or for non-covered service	Yes / No	None needed. We will check state databases to confirm.
Deceased with no estate	Yes / No	A copy of the patient's death certificate.
Mental incapacitation with no one to act on patient's behalf	Yes / No	Written statement from patient's physician or family
Community-based program enrollment	Yes / No	A letter from the program that certifies the patient's membership.
Personal bankruptcy	Yes / No	Legal documentation indicating bankruptcy.
Homeless	Yes / No	Shelter address: _____ _____ _____ Shelter phone: _(_____)_____
Incarceration	Yes / No	None needed. We will check state databases to confirm.

If the patient meets one of the Presumptive Eligibility Criteria above, you do not need to complete page 4 of this Application.

Complete this page only if the patient does not meet one of the Presumptive Eligibility Criteria on page 3 of this Application.

Patient's family income and employment information

Please list all sources of income including, but not limited to, employment, Social Security, retirement, interest, rental income, child support, alimony, and government assistance. Sources of income should be from the patient, the patients spouse or partner (if guarantor) or the patient's parent or guardian (if guarantor and patient is a minor). Attach additional pages if needed:

Household Member Name	*Source of Income/Benefit*	*Gross Monthly Amount*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach a copy of the prior year's Federal Income Tax return and all supporting W2 forms for the patient, the patient's spouse, or the patient's parents (if the patient is claimed as a dependent). Please also attach documentation of the family income you listed, which may include paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other appropriate documentation.