Shirley Ryan Abilitylab

Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Shirley Ryan AbilityLab ("SRAlab") determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please note that Financial Assistance is available only to residents of Illinois.

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 SRAlab in person, by mail, or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your Application for up to 240 days following the first billing statement for your care. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist SRAlab in determining whether the patient is eligible for financial assistance.

PATIENT INFORMATION			
Patient Name	Patient Social Security Number	Patient Date of Birth	
Patient Phone Number	Patient Home Address		
Patient Employer	Patient Employer Address		Monthly Income
SPOUSE/GUARANTOR INFORMATION			
Spouse/Guarantor Name	Relationship to Patient □ Spouse □ Partner □ Parent □ Other:		
Guarantor Phone Number	Guarantor Address		
Guarantor Employer	Guarantor Employer Address		Monthly Income

PRESUMPTIVE ELIGIBILITY CRITERIA

The information you provide on this section will help SRAlab determine if you are presumptively eligible to receive financial assistance. If you meet more than one criteria below, 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.
Recent personal bankruptcy	Yes / No	Legal documentation indicating recent bankruptcy.
Homeless	Yes / No	Shelter address: _____ _____ _____ Shelter phone: (_____) _____
Incarceration	Yes / No	None needed. We will check state databases to confirm.

IF PATIENT MEETS ANY PRESUMPTIVE ELIGIBILITY CRITERIA ABOVE,

YOU DO NOT NEED TO COMPLETE HOUSEHOLD INCOME SECTION OF THE APPLICATION

PATIENT INSURANCE INFORMATION

Please mark X below if the patient is covered under (or is a beneficiary of) any of the following health insurance programs:

□ Health Insurance □ Medicare □ Veterans' Benefits □ Other_____

□ Medicaid □ Medicare Supplement □ Uninsured _____

Is treatment provided related to any of the following?:

□ Accident □ Crime □ Workplace Injury □ Other:_____

HOUSEHOLD INCOME

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). ***Please see supporting documentation requirements on page 3 of this Application***, and attach additional pages if needed:

Household Member Name	Source of Income/Benefit	Gross Monthly Amount

DEPENDENT HOUSEHOLD MEMBERS (as reported on tax return)

Name	Age	Relationship

PROCEED TO PAGE THREE FOR SIGNATURE

SUPPORTING DOCUMENTS

Please provide the documents requested below. Your application may be delayed or denied if any required documents are not included. If you cannot provide an applicable document, please attached a written explanation.

Required

1. Identification: Please provide one of the following:
   - ☐ Government-issued photo ID, if available (e.g., State of Illinois Drivers License, State of Illinois Identification Card, Passport)
   - ☐ Other official form of identification

2. Proof of Illinois Residency: If you did not produce a current State of Illinois Drivers License or State of Illinois Identification Card for item #1 above, please provide at least one of the following documents, in your name:
   - ☐ Recent residential utility bill
   - ☐ Lease agreement
   - ☐ Illinois vehicle registration card
   - ☐ Voter registration card
   - ☐ Current mail addressed to applicant from the government or other credible source
   - ☐ Letter from homeless shelter
   - ☐ Statement from family member of patient who resides at the same address and presents verification of residency

3. Household Income Verification: Please provide the following documents, as applicable:
   - ☐ Most recent federal and state tax returns, including all schedules
   - ☐ Most recent W-2 and 1099
   - ☐ 2 most recent income stubs, including paychecks, unemployment benefits, and/or social security checks
   - ☐ Employer's written verification of income, if paid in cash
   - ☐ Statement of Alimony, business or retirement/pension income (if not reflected on most recent tax return, or if current year's amount will vary from that reflected in most recent tax return)

4. Assets: Please provide the following documents, if applicable:
   - ☐ Most recent statement for all checking, savings, and/or credit union accounts
   - ☐ Information regarding value of and income received from owned properties (buildings/land) other than primary residence
   - ☐ Other investment information (bonds, stocks, etc.) besides IRA/401k retirement and 529 college savings accounts

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) Name: _____

Patient (or Applicant) Signature: _____

Date: _____

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