



APPLICATION FOR FINANCIAL ASSISTANCE

The financial assistance program of Elmhurst Memorial Healthcare is designed to provide medical care for free or at a reduced cost if the recipient of the care is not able to pay fully for the services received. This program does not cover services that are provided by medical personnel not considered part of the hospital's medical staff; for example, radiologists or anesthesiologists not employed by the hospital.

Eligibility for this program is based on your income and resources, taking family size into account. Additionally, you must apply for and use any private health care coverage or government health care coverage (such as Medicare and Medicaid) available to you. Assuming your income and resources make you eligible for financial assistance, and you have exhausted any other available health care coverage, financial assistance coverage may be available to you.

You must submit any of the following documents as evidence of your eligibility: pay stubs, income tax returns from the previous year, W-2 statements, unemployment compensation forms approving or denying your claim, forms approving or denying Medicaid and/or state-funded medical assistance, and written statements from employers or welfare agencies, bank statements and/or brokerage firm statements. This list is not exclusive: if you have other documents that will support your eligibility, you may submit those documents as well. **Please do not send originals as the documents are securely shredded after a decision has been reached.**

Once the hospital has received the requested documentation from you, we will make every reasonable effort to make a determination and notify you of our decision within 30 calendar days.

Please fill out the form below as completely as possible. Should you have any questions regarding this application, please contact Rick DeVries at (331) 221-3208.

Applications should be mailed to:

Elmhurst Memorial Hospital
Attn: Rick DeVries/Room D1523
155 E. Brush Hill Road
Elmhurst, IL 60126

Name of Patient _____

Name of Applicant _____ Relationship to Patient _____

Daytime telephone () _____ Evening telephone () _____

EMH Patient Account Number (only 1 needed) _____



ELMHURST MEMORIAL HEALTHCARE Required Documents Checklist

In order to evaluate your application promptly, we require the completed application and the following information. **Please put a check next the documents attached.** If the item does not apply, please write **N/A.**

- ❖ _____ *Proof of income (Three most recent payroll stubs including spouse if applicable)*
- ❖ _____ *W2 wage statement for the previous year*
- ❖ _____ *Copy of Federal tax forms for the previous year*
- ❖ _____ *Copy of drivers license/photo ID*
- ❖ _____ *Copies of unemployment checks (if applicable)*
- ❖ _____ *Mortgage or rent receipts for last three months*
- ❖ _____ *Signed room and board letter (If living with friends or relatives)*
- ❖ _____ *Copies of last three bank statements including, checking, savings, etc.*
- ❖ _____ *Copies of credit card statements (last three months)*
- ❖ _____ *Copies of utility bills*
- ❖ _____ *Detailed letter explaining current living conditions/arrangements*

Please note that failure to provide the documents requested would result in a delay in processing or denial of your request. All sections of the application, along with all documentation, must be completed and returned to me no later than 30 days from the date the application was sent out. If not received in 30 days, all normal collection efforts will resume. If you have any questions, please feel free to contact me between the hours of 7 a.m. and 3:30 p.m. Monday – Friday. As always, thank you for choosing Elmhurst Memorial Healthcare.

Sincerely,

Rick DeVries
Financial Assistance Coordinator
Phone: (331) 221-3208
Fax: (331) 221-3773
Email: rdevrie@emhc.org



FAMILY SIZE

Please list the names of individuals whom you are financially responsible for.

Name of Dependent:	Relationship to Patient:

TOTAL FAMILY INCOME PER MONTH

Income should include those of yourself, your spouse, parents or others who live with you.

Gross Employment Income	\$
Social Security Income	\$
State Aid	\$
Food Stamps	\$
Pension	\$
Workers Compensation Income	\$
Child Support/Alimony	\$
Money from Family/ Other	\$
Rental Income	\$
TOTAL GROSS INCOME THIS MONTH	\$
TOTAL GROSS INCOME LAST 3 MONTHS	\$
TOTAL GROSS INCOME LAST 12 MONTHS	\$



TOTAL ASSETS

Include your assets and any current or expected income, including those of your spouse, parents, or others who live with you.

Type of Asset	Value
<p>Homes</p> <p>Address (Not P.O. Box) _____</p> <p>Homestead <input type="checkbox"/> Yes Mobile Home <input type="checkbox"/> Yes</p> <p>Balance Owed \$ _____</p>	\$
<p>Vehicles</p> <p>1st Car Year _____ Model _____</p> <p>2nd Car Year _____ Model _____</p> <p>Boat Year _____ Model _____</p> <p>Motor Home Year _____ Model _____</p>	\$ \$ \$ \$
<p>Other Property</p> <p><input type="checkbox"/> Rental <input type="checkbox"/> Vacant Land Balance Owed _____</p>	\$
<p>Bank Accounts</p> <p>Savings: Bank Name _____ Average Balance _____</p> <p>Checking: Bank Name _____ Average Balance _____</p> <p>CDs: Bank Name _____ Average Balance _____</p>	\$ \$ \$
<p>Other</p> <p>Stocks and bonds Broker Firm _____</p> <p>IRA</p> <p>Trusts</p> <p>401K</p>	\$ \$ \$ \$
<p>List Other Assets</p>	\$
<p>Value of All Assets Listed Above</p>	\$



MONTHLY LIVING EXPENSES

Expenses include, but not limited to, unpaid medical bills, credit card debts, automobile loans, mortgages, and routine medications, rent, etc. Please include due dates indicating which bills might be past due.

Payment To	For	Total Amount Owed	Amount Due Each Month	Amount Past Due
Medical	Elmhurst Hospital Other Hospitals Doctors Medication			
Housing	Home Mortgage 2 nd Mortgage Property Tax Rent Mobile Home Lot			
Food	Groceries School/Work Lunches			
Utilities	Electric, Garbage, Gas, Water, Phone			
Transportation	1 st Car, 2 nd Car Gasoline			
Loans	Boat/Motor Home Bank/Credit Union			
Charge Cards	Sum of all Credit Cards			
Family	Day Care/Baby Sitters			
Insurance	Auto, Medical, Life, Renters Insurance			
Miscellaneous	IRS/Judgments/ Liens/ Other			
	TOTALS			

Processing of this application will not begin until all supporting documentation for all income, assets and expenses has been received.



Elmhurst Memorial
Healthcare

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I understand that this application is made so that Elmhurst Memorial Healthcare can determine my eligibility for uncompensated services based on the established criteria on file. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action is deemed to be appropriate. I certify that the current information given is true and accurate to the best of my knowledge.

Signature of Applicant

Date