Important:

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help OSF HealthCare determine if you can receive free or discounted services or other public programs that can help pay for your health care. 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, 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.

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.

If patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the application's section on monthly expenses.

OSF FINANCIAL ASSISTANCE APPLICATION

Dear Patient,

We here at OSF HealthCare know our patients have concerns about their medical treatment, and we also know they have concerns about making payment on their account. This form will try to help you with your concerns about payment of your account.

The information in this application will be used to identify if you qualify for any methods of financial assistance. First, there is a discount offered by law to all Illinois patients without insurance that is available to persons who qualify. Second, we will use the information you give us in an effort to help you obtain payment from other sources. Finally, we offer OSF Financial Assistance. This is a contribution from OSF HealthCare to assist in the payment of your account for those who qualify.

Do you have questions about OSF Financial Assistance or the steps in the process? The staff at OSF HealthCare want to help you.

The contact information for all of the Illinois hospitals and OSF Home Care Services (OSF Patient Accounts and Access Center-PAAC), the OSF Medical Group and the OSF hospital facility in Escanaba, Michigan are on the back cover of this form.

Sincerely,

The Sisters of the Third Order of St. Francis

www.osfhealthcare.org

www.osfhealthcare.org

OSF Financial Assistance Application

Patient MRN:____________________

*I have received OSF Financial Assistance within the last 12 months. **Yes/No** from which facility ______________________

Patient's Name:____ Date of Birth:______________________

Social Security # (not required if you are uninsured):____________________________

Address:____

City:____ State:___________________ Phone #:___________________________

Patient was a resident of Illinois when care was received? ☐ Yes ☐ No

Employer:____ Phone #:___________________________

Spouse/Partner/Parent/Guardian:____

Address:____

City:____ State:___________________ Phone #:___________________________

Employer:____ Phone #:___________________________

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Other__________

Number of Dependents _____________ Monthly Child Support Paid $_____________________________________

Financial Information and Income

SOURCE:	Patient Amount/Frequency	Spouse/Partner/Parent/Guardian Amount/Frequency
Wages/Unemployment/Work Comp	$____________/____________	$____________/____________
Business Income/Self Employed	$____________/____________	$____________/____________
SS/SSI/SSD	$____________/____________	$____________/____________
Child Support/Alimony/Foster Care	$____________/____________	$____________/____________
VA: Pension, Disability, Benefit, other VA	$____________/____________	$____________/____________
Private Disability	$____________/____________	$____________/____________
Retirement, Pension	$____________/____________	$____________/____________
Interest or Dividend Income (Money Market, Stock, Bonds, CD, Mutual Funds, etc.)	$____________/____________	$____________/____________
Public Aid/Assistance	$____________/____________	$____________/____________
Other Income:________________________	$____________/____________	$____________/____________

(check any/all that apply)

☐ WIC ☐ SNAP ☐ LIHEAP ☐ IL Free Lunch & Breakfast

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.

Signature(s):____ Date:______________________

*Learn about the Illinois Hospital Uninsured Patient Discount Act and access general payment and financial assistance information online at: **www.osfhealthcare.org**

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Please complete this application, print and return all pages to the designated facility below.

OSF Patient Accounts and Access Center (PAAC)	P.O. Box 1701, Peoria, IL 61656-1701 (800) 421-5700 or (309) 683-6750
OSF Medical Group Offices-Patient Accounts	P.O. Box 1806, Peoria, IL 61656-1806 (800) 589-6070 or (309) 683-5990
OSF St. Francis Hospital & Medical Group in Escanaba, MI-Patient Accounts	3401 Ludington St., Escanaba, MI 49829-1377 (906) 786-5707 ext. 5550
OSF Saint Anthony's Health Center	P.O. Box 340 #1 Saint Anthony's Way Alton, IL 62002 (618) 465-4506 or (618) 465-4502

OSF Home Infusion Pharmacy
OSF Home Medical Equipment
2265 W. Altorfer Road, Peoria, IL 61615-1807
Home Infusion Pharmacy: (800) 446-3009
Home Medical Equipment: (877) 795-0416

An uninsured Illinois resident may apply for the Illinois Hospital Uninsured Patient Discount by completing this Application and submitting any one of the following documents to verify family income. OSF Healthcare may require additional documentation to apply for OSF Financial Assistance.

- ☐ Copy of most recent tax return
- ☐ Copy of most recent W-2 and 1099 forms
- ☐ Copies of 2 most recent pay stubs
- ☐ Written income verification from employer if paid in cash
- ☐ One other reasonable form of third party income verification deemed acceptable to the hospital

For OSF HealthCare Use Only			
Gross Family Income			
Legal Family Size			
Signature		Date	