OSF HEALTHCARE

www.osfhealthcare.org

OSF HealthCare Financial Assistance Application

Patient MRN:_____

PRINT | SAVE AS | EMAIL | RESET

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION

- ☐ Copies of 2 pay stubs for 30 Days for all income reported
- ☐ Submit a letter describing your financial situation
- ☐ Copies of unemployment statements for 30 days
- ☐ Copies of Social Security Benefits (if applicable)

Filed Federal income taxes? To request a copy of your taxes, please call 1-800-829-1040 (official transcript, **no hand written forms**)

- ☐ Yes – Please send the most recent Federal income tax returns and supporting schedules
- ☐ No – Please explain why:

I have applied for or will apply for federal or state medical assistance

☐ Yes (provide tracking # or denial letter) ☐ No–Not a citizen ☐ No–Over income ☐ No–Other reason, why?_____

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)

Other Wages		Misc. Income		Disability Income		Alimony	
Pension		Rental Income		Veterans Benefits		Unemployment	

PATIENT/RESPONSIBLE PARTY

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated (documentation required)

Name: (First, Middle, Last)	Social Security Number:	Birth Date: (MM/DD/YYYY)

Patient/Responsible Party Address:

Phone Number:	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐ Yes ☐ No If yes, provide tax return of those claiming you.
Household Size (Patient, Spouse & Dependents)	Employer Name and Address		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY) From: To:	Average Gross Monthly Income: (Amount before taxes) $	Monthly SSI/SSDI: $

SPOUSE (if applicable)

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated (documentation required)

Name (First, Middle, Last)	Social Security Number	Birth Date (MM/DD/YYYY)

Phone Number:	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐ Yes ☐ No If yes, provide tax return of those claiming you.
Household Size: (Patient, Spouse & Dependents)	Employer Name and Address:		
Hire Date: (MM/DD/YYYY)	Unemployed: (MM/DD/YYYY) From: To:	Average Gross Monthly Income: (Amount before taxes) $	Monthly SSI/SSDI: $

DEPENDENTS under age of 18 (If more than 3 dependents use a separate page)

Full Name	Relationship	Birth Date (MM/DD/YYYY)	Claimed as a Dependent on Taxes	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No

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 REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED

Patient/Responsible Party Signature(s)	Date

Dear Valued Patient,

We at OSF HealthCare know our patients have concerns about making payments on their accounts for medical treatment. This application will help you with your concerns about payment of your hospital, physician/ clinic or home care bills.

The information in this application will help us determine if you qualify for any type of financial assistance. OSF will use the information you provide in this application to determine if you are eligible for an uninsured discount, payment from other sources, or if you qualify for the OSF Financial Assistance Program.

Please visit our website at **osfhealthcare.org** or call our office about any questions you may have. We are here to help you!

Sincerely,
The Sisters of the Third Order of St. Francis

OSF HEALTHCARE

www.osfhealthcare.org

Please complete this application and return all requested documentation to OSF HealthCare

OSF HealthCare Patient Financial Services (includes MI)	P.O. Box 1701, Peoria, IL 61656-1701 (800) 421-5700 or (309) 683-6750 Fax (309) 308-3963
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

Please complete and return this application within 240 days of your first billing statement.

- Go to OSF MyChart to complete the application and upload documents (If you do not have an OSF MyChart account and need assistance setting it up, you can call our office for help – it is easy to do!), or
- Visit the OSF website at **osfhealthcare.org** to complete a Financial Assistance application and upload requested documents, or
- Complete this paper application and provide copies of the requested documents and send them to us by mail, fax or dropping off at any OSF facility

An uninsured patient may apply for an Uninsured Discount by completing this application and submitting any one of the following documents to verify family income. You may also qualify for OSF Financial Assistance, which requires some additional documents (see application for details).

- ☐ 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 by OSF HealthCare.

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 application and submit it through OSF MyChart, in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 240 days following the date the first billing statement is mailed to the patient.

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. OSF HealthCare cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. OSF HealthCare postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

OSF HEALTHCARE FINANCIAL ASSISTANCE APPLICATION