

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 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.

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 hospital, physician/clinic or home care 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.

Please call or visit our website at osfhealthcare.org to obtain a Financial Assistance application.

Sincerely,

The Sisters of the Third Order of St. Francis



OSF[®]

HEALTHCARE

www.osfhealthcare.org



OSF Financial Assistance Application

Patient MRN: _____

www.osfhealthcare.org

*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

Table with 3 columns: SOURCE, Patient Amount/Frequency, Spouse/Partner/Parent/Guardian Amount/Frequency. Rows include 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, 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

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 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	