

PO Box 1006
Skokie, IL 60076
(847) 570-5000

Date:

PATIENT NAME:
ACCOUNT:
BALANCE: \$
DATE OF SERVICE

Dear _____ :

This Financial Statement packet is being provided to you for completion so that we may determine if you qualify for a discount under the NorthShore University HealthSystem Assistance Program.

**COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY
FOR NorthShore University HealthSystem FINANCIAL ASSISTANCE.**

If you do not complete this packet, or if you return it without the requested documentation, then NorthShore University HealthSystem will not be able to determine whether you qualify for Financial Assistance and you will be responsible for the balance due on your account.

To determine if you qualify for Financial Assistance, please return the information checked-off below with this completed packet:

- 2-4 paycheck stubs for last 2 months
- Current proof of income from all other sources; such as Unemployment Compensation, Disability Income, SSI, rental property income, pensions, annuities, interest payments, etc.
- Copies of bank statements for checking, savings, Certificates of Deposit, etc. for the last two months
- Confirmation of Support Letter
- Other - Last Income Tax Return

Please mail this completed packet and the requested documentation within 10 business days from the date of this letter. A letter of determination will be mailed to you within 21 days upon the receipt of your application.

Failure to complete this packet or to return it without all of the documentation requested will affect our ability to determine whether you qualify for a reduction of your bill or an extended payment plan.

Thank You,
Business Office Liaison
NorthShore University HealthSystem
(847) 570-5000

CRS initial: _____

FINANCIAL DISCLOSURE

APPLICANT/GUARANTOR INFORMATION		YEARS AT ADDRESS		HOME PHONE	
ADDRESS		OWN	RENT	BOARD	
CITY		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
STATE	ZIP CODE	DRIVERS LICENSE NUMBER			
LIST DEPENDANTS INCLUDING SELF		RELATIONSHIP TO APPLICANT		AGE OF DEPENDANT	
APPLICANT'S EMPLOYMENT AND INCOME INFORMATION			EMPLOYER ADDRESS		
CITY		STATE	ZIP CODE	EMPLOYER'S PHONE NUMBER	
OCCUPATION	YEARS AT EMPLOYER	GROSS PAY		FREQUENCY OF PAY	
OTHER INCOME AMOUNT		FREQUENCY OF OTHER INCOME		SOURCE OF OTHER INCOME	
SPOUSE'S EMPLOYMENT AND INCOME INFORMATION			EMPLOYER ADDRESS		
CITY		STATE	ZIP CODE	EMPLOYER'S PHONE NUMBER	
OCCUPATION	YEARS AT EMPLOYER	GROSS PAY		FREQUENCY OF PAY	
OTHER INCOME AMOUNT		FREQUENCY OF OTHER INCOME		SOURCE OF OTHER INCOME	

I/we voluntarily disclose this information to NorthShore University HealthSystem, and certify the information to be true and correct. I/we understand that as guarantor(s) on record, I/we are responsible for the account balance(s) due to the Hospital and that this information will be used by the Hospital to determine eligibility for Financial Assistance. I further understand that this information will be kept confidential by the Hospital, and will only be shared with physicians and other health care providers if it is directly related to the care provided, or if it is needed for further consideration for eligibility for Financial Assistance.

Applicant Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

EXPENSE DESCRIPTION	CREDITOR	MONTHLY PAYMENT DUE	BALANCE DUE
Rent/Mortgage			
Utilities:			
Electric			
Water			
Gas			
Phone			
Auto Loan 1			
Auto Loan 2			
Credit Card 1			
Credit Card 2			
OTHER MONTHLY EXPENSES – please itemize below			
TOTAL MONTHLY PAYMENTS AND EXPENSES:			
ASSET DISCLOSURE	ESTIMATED VALUE	OTHER- please itemize	ESTIMATED VALUE
Real Estate 1			
Real Estate 2			
Savings			
Certificates of Deposit			
Stocks			
Bonds			
Money Market Funds			
Insurance Policies			
MAXIMUM MONTHLY PAYMENT YOU CAN PAY ON YOUR ACCOUNT(S) =			

APPLICANT'S INITIALS: _____ SPOUSE'S INITIALS: _____

RE:

Date:

Dear _____,

The person named above has advised us that you are their sole means of support. To verify this information, please complete this form and return it to us as soon as possible. A return envelope has been provided for your convenience. Thank You.

The type of support I/WE provide is: (please complete all that apply)

_____ **Room and board**

_____ **Allowance of \$** _____

Every week _____

Every 2 weeks _____

Every month _____

_____ **Other support (please explain)** _____

Signature of person completing form

Date

Relationship to person named above