

FINANCIAL ASSISTANCE
ELIGIBILITY GUIDELINES

Dear Patient:

Below is a list of important documentation that you will need to know regarding your application for financial assistance.

All verification documents must be submitted as soon as possible. A return envelope has been provided for your convenience. If the verification documents are not received shortly, we will assume you have the ability to make payment and request that you please contact our Account Resolution Department to establish payment arrangements for your hospital bill(s).

IMPORTANT INFORMATION:

Eligibility is based on current Federal Poverty Guidelines as defined in the Federal Register.

Any extenuating family situations may also be considered in the final determination of assistance.

PROOF OF INCOME:

In order to establish your Annual Net Income, the following documentations are required.

- Last four (4) pay stubs, yearly ledger to date if self-employed and/or proof of child support.
- Three most recent bank statements.
- Copy of last years W2 forms.
- Copy of last years complete tax form.
- Room and Board Letter if applicable or Rent Receipt
- Drivers License (Photo I.D.)
- Social Security card
- Please provide us with any extenuating family situations that may be considered in the final determination of assistance.

Questions?

Please feel free to call our office Sunday – Saturday 8:00am – 11:00 pm at (773) 947-7500 Ext. 7996 or 7997

Please send copies of above documents to the below address or fax number:

Jackson Park Hospital
7531 S. Stony Island Ave.
Chicago IL 60649

Attention: Financial Assistance Department
(773) 947-7998

JACKSON PARK HOSPITAL
(773) 947-7500
Sunday through Saturday
8:00 AM– 11:00 PM

Patient's Name: _____

Account No. _____

DOCUMENTS NEEDED FOR ASSISTANCE

The documents checked below are needed in order for the Department of Human Services to complete your case. Please send copies to Jackson Park Hospital. **Please call your representative every two weeks.** Your representative at Jackson Park Hospital is (Los documentos marcados son necesarios para completar su solicitud para la Ayuda Publica. **Por favor llame a su representante una vez la semana.** Su representante de cuenta es :)

Name/Nombre: Ms. Rivera
Address/Dirección: 7531 S. Stony Island Ave.
Chicago IL 60649
Attention: Financial Assistance Department

- _____ Alien Card/Passport (Tarjeta de residencia o pasaporté)
- _____ Bank Statement (Balance de cuenta de banco) (for the last 3 months)
- _____ Birth Certificate (Acta de nacimiento)
- _____ Car Title/Plate Registration (Titulo del carro o registro)
- _____ Death Certificate (Acta de defunción)
- _____ Divorce Decree (Acto de divorcio)
- _____ Photo ID or Driver's License (Licencia de manejar)
- _____ Income Verification (Prueba de ingreso – talons de cheques)
- _____ Insurance Policy (Póliza de seguro)
- _____ Marriage License (Acta de Matrimonio)
- _____ Rent Receipts (Recibos de renta) (for the last 3 months)
- _____ Room and Board Letter (Carta de mantenimiento)
- _____ Social Security Award Letter (Carta de beneficios del seguro social)
- _____ Social Security Card (Tarjeta de seguro social)
- _____ Unemployment Card (Tarjeta de desempleo)
- _____ Utility Bills (1) (Recibos de gas, electricidad, o teléfono)
- _____ Tax Return (net income) last year
- _____ Other **PLEASE RETURN DOCUMENTS AS SOON AS POSSIBLE. THANK YOU.**

FINANCIAL ASSISTANCE APPLICATION FORM

(Use reverse or additional paper if needed.)

Patient
Name: _____ Account: _____

Responsible Party
Name: _____ Phone: Day _____ Evening _____

Address: _____ City/State/Zip _____

List All Sources Of Your Monthly Gross Income:

Responsible Party's Salary Before Deductions \$ _____ Pension \$ _____

Spouse's Salary Before Deductions \$ _____ Pension \$ _____

Social Security \$ _____ Unemployment \$ _____

Child Support \$ _____ Other \$ _____

Investment Income \$ _____

Available Assets:

Checking \$ _____ Savings \$ _____

Property \$ _____ Liquid Assets (Stocks/Bonds/Ira's/CD) \$ _____

Other \$ _____

Monthly Expenses:

Rent/Mortgage/Room & Board \$ _____

Medical Insurance \$ _____ Monthly Medical Expenses \$ _____

Loans \$ _____ Other \$ _____

Total Monthly Expenses \$ _____

I here by state that the information provided in this document is true and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Have you applied for financial assistance at Jackson Park Hospital in the last 12 months?

Yes No

THE FOLLOWING NOTICE DESCRIBES HOW YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to healthcare professions for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released for the purpose of a Jackson Park Hospital client receiving payments for providing you with needed healthcare services.
- Your confidential healthcare information may be released to the Social Security Administration (SSA) and/or your state's Disability Determination Unit (DDU) for the purpose of assisting you with the federal disability application.
- Your confidential healthcare information may be released to specific social service agencies for the purpose of assisting you with social service needs and identified resources.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public healthcare organization or federal organization in the event of an untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at anytime.
- You have the right to restrict the use of your confidential healthcare information. However, Jackson Park Hospital may choose to refuse your restriction if it is a conflict of providing you with quality healthcare or in the event of an emergency situation or receiving payment of services or if the restriction is in conflict with the services Jackson Park Hospital is contractually bound to provide to its client.
- You have the right to receive confidential communications about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.

PRIVACY NOTICE (continued)

- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of electronic transmission or on paper.
- Jackson Park Hospital is required by law to protect the privacy of health information. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Jackson Park Hospital will abide by the terms of this notice. Jackson Park Hospital reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to Jackson Park Hospital if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

**Jackson Park Hospital
7531 S. Stony Island Ave.
Chicago, IL 60649**

- All complaints will be investigated. There will be no personal issues raised as it pertains to filing a complaint with Jackson Park Hospital. To request information regarding the Jackson Park Hospital Privacy Policy, please write;

**Jackson Park Hospital
7531 S. Stony Island Ave.
Chicago, IL 60649**