City of Hope®

COH Chicago Financial Assistance Evaluation Form

As part of our commitment to serve the community, COH elects to provide financial assistance to patients who are uninsured or under-insured and satisfy certain requirements.

Financial assistance is not considered to be a substitute for personal responsibility, and patient families are expected to cooperate by providing complete and accurate information so COH can determine a patient's eligibility for our financial assistance program, and to contribute to the cost of the patient's care based on individual ability to pay.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

To determine if a patient qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help COH Chicago determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. 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 in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 240 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 COH in determining whether the patient is eligible for financial assistance.

State of Illinois Residents Only

IF YOU ARE UNINSURED AND DEMONSTRATE ONE OF THE SPECIFIC PRESUMPTIVE ELIGIBILITY CRITERIA LISTED BELOW, YOU ARE NOT REQUIRED TO COMPLETE THE APPLCATION. For questions on presumptive eligibility criteria, please contact Patient Accounts at 800-677-5545
Monday through Thursday 8:00 am – 4:00 pm CST or Friday from 8:00 am – 2:00 pm CST.

Do you meet any of the following criteria?

Homelessness

Deceased with no estate

Mental incapacitation with no one to act on patient’s behalf

Medicaid eligibility, but not on date of service or for non-covered service

Enrollment in assistance programs for low-income individuals

Women, Infants, and Children Nutrition Program (WIC)

Supplemental Nutrition Assistance Program (SNAP)

Illinois Free Lunch and Breakfast Program (LIHEAP)

Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership

Receipt of grant assistance for medical services

*Please include any supporting documentation with your application.

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City of Hope

Applicant Information

Full Name: ______________________ ______________________ ______ ______________

Last" *Hktuv"* M.I. Date of birth

Address: ______________________ ______________________________

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Ekv{" ____________________ *Uvcvg"* ______________ *\KR'Eqfg"* __________

Phone: ____________________ Email: ______________________________

Med Rec#: __________ Social Security#: ____________ Annual Household Income: ______________

Employed? Yes / No

Employer Info:

____

Does the patient have Health Insurance? Yes / No

Has the patient applied for Medicaid? Yes / No If Yes, date patient applied: _________

Is the patient on Social Security Disability? Yes / No

Additional Info:

____

____

Dependent Information

Number of Dependents: __________ Ages: ______________________

Spouse/Partner/Guarantor Information

Spouse/Partner/Guarantor: Yes / No Employed: Yes / No

Name: ______________________ Employer: ______________________

Relationship: ______________________ Email: ______________________

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Disclaimer and Signature

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including the use of third-party validation programs, and subject to review by federal and/or state agencies and others as required and that at any time during the application process additional information may be requested. I understand that if any information I have given proves to be untrue, City of Hope will re-evaluate my financial status and any assistance granted may be reversed and I will be responsible for the payment of any balances. Any approval for financial assistance will be effective for a maximum of 6 months. A new Application will be required for the re-determination of your eligibility of Financial Assistance after the 6-month approval period.

Signature: ______________________________ Date: ________________

Additional Information

Additional Patient Information (Optional): Responses to these questions are OPTIONAL. Responses or choosing not to respond will not have any effect on whether patient is eligible for financial assistance.

Race/Ethnicity: ______________________________ Sex: ______________________________

Preferred Language: ______________________________

Completed forms may be:

- Electronically signed and submitted

OR any of the following

1. Emailed to PtAcctsFinancialHardshipTeam@ctca-hope.com
2. Returned to the hospital financial counselors
3. Mailed to:

   COH – Patient Accounts
   2610 Sheridan Road
   Zion, IL 60099

- COH reserves the right to review a credit report for you and your spouse as needed.
- COH may ask for additional documentation including but not limited to W2's, Most Recent Tax Return, Social Security Statement, Proof of life changes, etc.
- COH may review accounts held for outstanding insurance payments that have been sent to the member

Once all information is received, COH will respond within 30 days to your request for financial assistance. Should we need additional information to process your request we will contact you via phone or email. You will be notified by mail of your eligibility once the application and all documentation is received and processed; standard collection procedures will continue until complete information is received.

For status or questions, please contact Patient Accounts at 800-677-5545
Monday through Thursday 8:00 am – 4:00 pm CST or Friday from 8:00 am – 2:00 pm CST.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 877-305-5145
(TTY 800-964-3013).

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