**Section 4500.30 Hospital Financial Assistance Application Requirements**

Hospital financial assistance applications shall be provided to patients on forms that are submitted annually, in conjunction with a hospital's filing of its Community Benefits Report as required by the Community Benefits Act or filing of Worksheet C as required by the Hospital Uninsured Patient Discount Act, to the Office of the Attorney General for review of compliance with this Part. Hospital Financial Assistance Applications for each hospital shall be in English and in any other language that is the primary language of at least 5% of the patients served by the hospital annually as identified for purposes of Section 15(c) of the Act. Information requested on the application shall include:

a) Opening Statement, which shall contain the following paragraphs:

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help \_\_\_\_ Hospital 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 to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 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 the hospital in determining whether the patient is eligible for financial assistance.

NOTE: The requirement to complete and submit this form within 60 days following the date of discharge or receipt of outpatient care referenced in the Opening Statement may be increased by the hospital, but may not be decreased.

b) Patient information, which shall be limited to the following:

1) Patient name;

2) Patient date of birth;

3) Patient address;

4) Whether patient was an Illinois resident when care was rendered by the hospital;

5) Whether patient was involved in an alleged accident;

6) Whether patient was a victim of an alleged crime;

7) Patient Social Security Number (not required if you are uninsured);

8) Patient telephone number or cell phone number;

9) Patient e-mail address;

10) In cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is guarantor for a minor, the name, address and telephone number of the guarantor.

NOTE: The hospital may choose to not include the information in this subsection (b)(10).

c) Family/household information, which shall be limited to the following:

1) Number of persons in the patient's family/household;

2) Number of persons who are dependents of the patient;

3) Ages of patient's dependents.

d) Patient's family income and employment information, which shall be limited to the following:

1) Whether patient or patient's spouse or partner is currently employed;

2) If patient is a minor, whether patient's parents or guardians are currently employed;

3) If patient or patient's spouse or partner is employed, name, address and telephone number of all employers;

4) If a minor patient's parents or guardians are employed, name, address and telephone number of all employers;

5) If patient is divorced or separated or was a party to a dissolution proceeding, whether the former spouse or partner is financially responsible for patient's medical care per the dissolution or separation agreement;

6) Gross monthly family income, including cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is guarantor for a minor, from sources such as:

A) Wages;

B) Self-employment;

C) Unemployment compensation;

D) Social Security;

E) Social Security Disability;

F) Veterans' pension;

G) Veterans' disability;

H) Private disability;

I) Workers' compensation;

J) Temporary Assistance for Needy Families;

K) Retirement income;

L) Child support, alimony or other spousal support;

M) Other income;

7) Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

e) Insurance/benefit information, including but not limited to:

1) Health insurance;

2) Medicare;

3) Medicare Part D;

4) Medicare Supplement;

5) Medicaid;

6) Veterans' benefits.

f) Asset and estimated asset value information, which shall be limited to the following:

1) Checking;

2) Savings;

3) Stocks;

4) Certificates of deposit;

5) Mutual funds;

6) Automobiles or other vehicles;

7) Real property;

8) Health savings/Flexible Spending Account.

g) Monthly expense information and estimated expense figures, which shall be limited to the following:

1) Housing;

2) Utilities;

3) Food;

4) Transportation;

5) Child care;

6) Loans;

7) Medical expenses;

8) Other expenses.

h) Certification, which shall contain only the following paragraph:

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.

Patient or Applicant Signature and Date.

i) The application shall contain a notation that, if a patient meets the presumptive eligibility criteria established in Section 4500.40 or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures set out in subsection (g).

(Source: Amended at 38 Ill. Reg. 20263, effective October 10, 2014)