IMPORTANT INFORMATION

*** Application must be returned within 30 days of Assistance request ***

Return to: Alexian Brothers Health System Business Office
Attn: Assistance Department
3040 Salt Creek Lane
Arlington Heights, IL 60005

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

All verification documents must be submitted within 30 days of the date assistance is requested. If the verification documents are not received in our offices during this 30 day period, we will assume you have the ability to make payment and request that you please contact our Patient Financial Services Department to establish payment arrangements for your hospital bills.

IMPORTANT INFORMATION

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

Any extenuating family situations may be also be considered in the final determination of assistance. Please also include a letter outlining these circumstances.

PROOF OF INCOME REQUIRED: In order to establish your annual gross income, the following documentation is required.

- Last four (4) pay stubs, business ledger, if self employed, proof of child support, unemployment stubs, SSI annual award letter, 1099, or income verification from employer.
- Copy of last year's W2 or 1099 forms.
- Copy of last year's complete Federal tax return.
- Last three months of complete bank statements.
- Signed room and board letter, if you depend on someone else to help you meet all or part of your daily living expenses.
- If any of the required documents are unavailable, please include a letter with an explanation of why you cannot send copies for consideration in the final determination of assistance.

QUESTIONS?

Please feel free to call us at 866/690-3370.

Or email your questions to - AlexianAssistance@alexian.net

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR ALEXIAN ASSISTANCE

PATIENT NAME: ____

ACCOUNT NUMBER(S) ____

RESPONSIBLE PARTY/GUARANTOR NAME: ____

I understand that the information, which I will submit concerning my annual income and family size, is subject to verification.

____
Last Name First Name M.I. Telephone No.

____
Street Address City/State Zip Code

Name and Address of Employer ____

____

____

Name and Address of Spouse's Employer_______________________________________

____

____

Guarantor/Patient Social Security Number_______________________________

Please list all family member(s) who live with you (including yourself)

Name	Age	Relationship

FINANCIAL DISCLOSURE FORM

Patient Name: ____

Account Number (s) ____

Responsible Person /Guarantor Name: ____

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 $ _____________________________

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

____
Print Name:

____
Signature Date

ROOM AND BOARD STATEMENT

Date:

Patient Name:
Account Number (s):

Name: ____

Address: ____

____

Phone: ____

Relationship: _____________________________________

To Whom It May Concern:

I have provided room and board to ____________________________________

for the past _____________________________________.

I can continue to provide room and board for the above named person but am unable to contribute toward his/her medical expenses.

____

Signature Date