Adventist
Midwest Health
A Member of Adventist Health System

Adventist Hinsdale Hospital • Adventist La Grange Memorial Hospital • Adventist GlenOaks Hospital • Adventist Bolingbrook Hospital

Financial Assistance

ACCOUNT #: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

PATIENT NAME: _____

You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients.

If you are Uninsured:

Adventist Midwest Health offers all **uninsured** patients a 65% discount off of total charges. If you pay today, or within 5 days from service date, an additional prompt pay discount of 20% of the remaining balance will be applied to your account, bringing the total discount to 72% of the total charges.

Patients without the ability to pay for services rendered, even with these discounts, may be considered for one of our financial assistance programs. If you wish to be considered for additional financial assistance beyond the stated discounts above, please place an "X" on the appropriate line below and complete the Financial Assistance Application on the reverse side of this form.

If any insurance benefits are identified related to your Hospital service, this agreement will become null and void, and any discount offered will be withdrawn.

If you are insured or have Medicare:

Patients without the ability to pay their deductibles and/or co-pays/co-insurance amounts may be considered for one of our financial assistance programs. If you wish to be considered for financial assistance please place an "X" on the appropriate line below and complete the Financial Assistance Application on the reverse side of this form.

The above discounts are for **hospital charges ONLY**. Fees for physicians or other medical professionals that may be providing you with service(s) during the course of your visit will be billed separately.

____ I do need Financial Assistance **____ I do not need Financial Assistance**

_____ / _____ _____

Patient/Guarantor Signature / Relationship Witness

_____ _____

Print Print

_____ _____

Date Date

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FINANCIAL ASSISTANCE APPLICATION FORM

QUESTIONS? Call (630) 856-8400

Adventist Hinsdale Hospital • Adventist La Grange Memorial Hospital • Adventist GlenOaks Hospital • Adventist Bolingbrook Hospital

Charity or financial assistance may be available to qualified hospital patients who submit this completed application to the address listed to the right below. Applicants will be notified of determination within thirty days of receipt.

Return this completed form to:
Adventist Midwest Health
Financial Assistance Department
P. O. Box 9246
Oak Brook, IL 60522
or fax to (630) 312-7981

Application is for hospital charges only, and does not cover physician charges.

Account Number ☐☐☐☐☐☐☐☐

Patient Last Name, First	Social Security Number	Date Of Birth	Age
Parent's Name, if patient is a minor	Parent's Social Security Number	Date Of Birth	
Patient's Address			
Are you, or will you be, disabled for a year? ☐ YES ☐ NO Are you blind? ☐ YES ☐ NO Number of children under the age of 18			
Family Size	$ * Last 12 Months Annual Household Income	Home Phone #	Cell Telephone # (optional)

***Proof of income (1040 tax return) is required for debts of $20,000 or higher. Proof of income may be requested for debts less than $20,000.**

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill and will take all action necessary to obtain assistance from the above sources. I understand that if I do not cooperate with the hospital within 45 days from the date of service in supplying ANY additional requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the IL Department of Human Services to disclose to the hospital ALL information regarding the status of my Medicaid application and, if the application is not approved the reason for disapproval. I will ASSIGN the HOSPITAL ALL FUNDS received from the above sources which are provided to help with this HOSPITAL BILL.

I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to hospital charges and not physician's charges. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate.

SIGNATURE OF APPLICANT **DATE**

PFS Financial Assistance Application Form 01/11/06
Revised 07/17/06
Revised 06/26/2007-TG
Revised 01/03/2008-ABH