Shirley Ryan Abilitylab

Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE FROM SRALAB OR PHYSICIANS EMPLOYED DIRECTLY BY SRALAB. Completing this Financial Assistance Application ("Application") will help Shirley Ryan AbilityLab ("SRAlab") determine if you can receive free or discounted services, or if there are other public programs that may be able to help pay for your health care. Please note that Financial Assistance is only available to residents of Illinois.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DSCOUNTED CARE. However, providing a Social Security number will help SRAlab determine whether you qualify for any public programs. A Social Security number **is** required for some public programs, including Medicaid.

To apply for free or discounted care, please complete this form and submit it to SRAlab in person, by mail, or by fax as soon as possible after your first date of service. We will accept your Application for up to two-hundred forty (240) calendar days following the first billing statement for your care. If we determine that your Application is incomplete, we will request additional information and will provide you with thirty (30) calendar days to submit it.

By signing and submitting this Application, you acknowledge that you have made a good faith effort to provide all information requested to assist SRAlab in determining whether you are eligible for financial assistance, and you agree to communicate any change in financial situation within thirty (30) calendar days of a change.

For purposes of this Application, "you" refers to the patient, even if someone else is completing the Application on the patient's behalf.

PATIENT INFORMATION		
Patient's Name	Patient's Social Security Number	Patient's Date of Birth
Patient's Phone Number	Patient's Home Address	
Patient's Employer	Patient's Employer Address	Patient's Monthly Income

PATIENT INFORMATION – OPTIONAL This section is optional. A patient's responses or non-responses will have no impact on the outcome of the Application.	
Patient's Race	Patient's Ethnicity
Patient's Sex	Patient's Preferred Language

SPOUSE/GUARANTOR INFORMATION		
Spouse's /Guarantor's Name	Guarantor's Relationship to Patient □ Spouse □ Partner □ Parent □ Other: _____	
Guarantor's Phone Number	Guarantor's Address	
Guarantor's Employer	Guarantor's Employer Address	Guarantor's Monthly Income

PATIENT INSURANCE INFORMATION
Please mark an X below if the patient is covered under (or is a beneficiary of) any of the following health insurance programs: □ Health Insurance □ Medicare □ Veterans' Benefits □ Medicaid □ Medicare Supplement □ Uninsured □ Other: _____
Is treatment provided related to any of the following: □ Accident □ Crime □ Workplace Injury □ Other: _____

PRESUMPTIVE ELIGIBILITY CRITERIA		
The information you provide on this section will help SRAlab determine if you are presumptively eligible to receive financial assistance. If you meet more than one criteria below, you only need to provide supporting documentation for one of the criteria you meet.		
Criteria	**Circle Yes / No**	**Include this Supporting Information with Your Application**
Women, Infants, and Children Nutrition Program (WIC) Enrollment	Yes / No	A copy of any document, such as a letter, that shows that the patient is receiving such assistance.
Supplemental Nutrition Assistance Program (SNAP) Enrollment	Yes / No	
Illinois Free Lunch and Breakfast Program Enrollment	Yes / No	
Low Income Home Energy Assistance Program (LIHEAP) Enrollment	Yes / No	
Receipt of grant assistance for medical services	Yes / No	
Medicaid eligible, but not on date of service or for non-covered services	Yes / No	None needed. We will check state databases to confirm.
Deceased with no estate	Yes / No	A copy of the patient's death certificate
Mental incapacitation with no one to act on patient's behalf	Yes / No	Written statement from patient's physician or family
Community-based program enrollment	Yes / No	A letter from the program that certifies the patient's membership
Recent personal bankruptcy	Yes / No	Legal documentation indicating recent bankruptcy
Homeless	Yes / No	Shelter address: _____ _____ _____ Shelter phone number: (_____) _____
Incarceration	Yes / No	None needed. We will check state databases to confirm.

IF YOU MEET ANY OF THE PRESUMPTIVE ELIGIBLITY CRITERIA LISTED ABOVE, YOU DO NOT NEED TO COMPLETE THE HOUSEHOLD INCOME SECTION OF THE APPLICATION BELOW

HOUSEHOLD INCOME (To be completed only if you did not meet any of the presumptive eligibility criteria listed above)		
Please list all sources of income including, but not limited to, employment, retirement, interest, and rental income. Sources of income should be from the patient, the patient's spouse or partner (if guarantor), or the patient's parent or guardian (if guardian is the guarantor and the patient is a minor). ***Please see supporting documentation requirements section of this Application (below), and attach additional pages if needed.***		
Household Member Name	**Source of Income / Benefit**	**Gross Monthly Amount**

DEPENDENT HOUSEHOLD MEMBERS (as reported on tax return)		
Name	**Age**	**Relationship to the Guarantor (when patient is under age 18)**

SUPPORTING DOCUMENTS

Please provide the documents requested below. Your application may be delayed or denied if any required documents are not included. If you cannot provide an applicable document, please attach a written explanation.

REQUIRED

1. Identification: Please provide one of the following:
   - □ Government-issued photo ID, if available (e.g., State of Illinois Driver's License, State of Illinois Temporary Visitor's Driver's License, State of Illinois Identification Card, Passport)
   - □ Other official form of identification

2. Proof of Illinois Residency: If you did not produce a current State of Illinois Driver's License, State of Illinois Temporary Visitor's Driver's License, or State of Illinois Identification Card for item #1 above, please provide at least one of the following documents, in your name:
   - □ Recent residential utility bill
   - □ Lease agreement
   - □ Illinois vehicle registration card
   - □ Voter registration card
   - □ Current mail addressed to applicant from the government or other credible source
   - □ Letter from homeless shelter
   - □ Statement from family member of patient who resides at the same address and presents verification of residency

3. Household Income Verification: Please provide the following documents, as applicable:
   - □ Most recent federal and state tax returns, including all schedules
   - □ Most recent W-2 and 1099
   - □ Two (2) most recent income stubs, including paychecks and/or unemployment benefits
   - □ Employer's written verification of income, if paid in cash
   - □ Business or retirement/pension income (if not reflected on most recent tax return, or if current year's amount will vary from that reflected in most recent tax return)

4. Assets: Please provide the following documents, if applicable:
   - □ Most recent statement for all checking, savings, and/or credit union accounts
   - □ Information regarding value of, and income received from, owned properties (buildings/land) other than primary residence
   - □ Other investment information (bonds, stocks, etc.,) other than the amounts held in, but not distributed from, IRA/401k retirement and 529 college savings accounts

PATIENT CERTIFICATION

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. I agree to notify the hospital within thirty (30) calendar days if there is a change in my financial situation that may impact my eligibility for financial assistance.

Patient (or Applicant) Name: _____

Patient (or Applicant) Signature: _____

Date: _____

Please call our Patient Financial Services Department at (312) 238-6039 if you have any questions or concerns regarding this Application. Return your completed Application and supporting documents to:

By mail or in person:
Shirley Ryan AbilityLab
Patient Financial Services Department
Financial Assistance Program
355 E. Erie St.
Chicago, IL 60611

By fax:
(312) 238-7569

Complaints or concerns with the uninsured 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), or online at https://illinoisattorneygeneral.gov/consumers/hcform.pdf.