Financial Assistance Application Form

Important: You may be able to receive free or discounted care: Completing this application will help AdventHealth 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 address listed on the cover letter.

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 AdventHealth determine whether you qualify for any public programs. For any application questions marked "optional," your response (or non-response) will not have any impact on the outcome of the application.

Please complete this form and submit it to AdventHealth in person, by mail, by email, or by fax to apply for free or discounted care as soon as possible after the date of service. We will accept your application for up to 240 days following the first billing statement for your care. By submitting this application, you acknowledge that you have made a good faith effort to provide all information requested in the application to assist AdventHealth in determining whether the patient is eligible for financialassistance. If you have any questions on the application process, you may contact AdventHealth's financial counseling department at 800-462-0490.

You may report complaints or concerns with the uninsured patient discount application process or hospital financial assistance process to the Health Care Bureau of the Illinois Attorney General. The Health Care Bureau's toll-free hotline is 1-877-305-5145 (TTY 1-800-964-3013).

Patient Information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Date: _____ Account number: _____

Name (first and last):

_____

Birth date: _____ Marital status: _____ Phone number: _____

Optional *– Gender Identity – Do you think of yourself as:* ☐ Male ☐ Female ☐ Transgender man/trans man/female-to-male (FTM)

☐ Transgender woman/trans woman/male-to-female (MTF) ☐ Genderqueer/gender nonconforming ☐ Neither exclusively male nor female

☐ Additional gender category (or other)

Optional: *Gender Identity: What sex was originally listed on your birth certificate?:* ☐ Male ☐ Female

Optional: *Race*: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Optional: *Ethnicity*: ☐ Hispanic, Latino/a, or Spanish origin ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin

Optional: *Language: Do you speak a language other than English at home?* ☐ Yes ☐ No
If yes, which language? _____

Optional: Preferred Language: ☐ English ☐ Spanish ☐ Polish ☐ Other: _____

Mailing address: _____ City: _____
State: _____ ZIP: _____

Optional: *Social Security Number:* _____

Employer: _____
Employment status: _____

Employer phone number: _____

Responsible Party's Information/Legal Guardian's Information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last): _____

Birth date: _____ Marital status: _____ Phone number: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Social Security Number (optional): _____

Employer: _____ Employment status: _____

Responsible Party Spouse Information

(If patient is same as responsible party, fill in spouse information for patient.)
Name (first and last): _____

Birth date: _____ Marital status: _____ Phone number: _____

Mailing address: _____ City: _____ State: _____ ZIP:

Social Security Number (optional): _____

Employer: _____ Employment status: _____

Employer phone number: _____

Dependents of Responsible Party

(If the patient is same as responsible party, fill in spouse information for patient.)

Name: _____ Birth date: _____

Relationship to responsible party: _____

Name: _____ Birth date: _____

Relationship to responsible party: _____

Name: _____ Birth date: _____

Relationship to responsible party: _____

Name: _____ Birth date: _____

Relationship to responsible party: _____

Number of adults and children living in household: _____

Monthly Income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income:

_____

Applicant spouse income:

_____

Social security benefits:

_____

Pension/retirement income:

_____

Disability income:

_____

Unemployment compensation:

_____

Worker's compensation:

_____

Interest/dividend income:

_____

Child support received: _____

Alimony received: _____

Rental property income: _____

Food stamps: _____

Trust fund distribution received: _____

Other income: _____

Total gross monthly income: $ _____

Monthly Living Expenses

Patients who are presumptively eligible for financial assistance as described in AdventHealth's Financial Assistance Policy are not required to complete this section.

Mortgage/rent:

_____

Utilities:

_____

Phone (landline):

_____

Cell phone:

_____

Groceries/food:

_____

Cable/internet/satellite TV:

_____

Car payment:

_____

Childcare: _____

Assets

Child support/alimony: _____

Credit cards: _____

Doctor/hospital bills: _____

Auto insurance: _____

Home/property insurance: _____

Medical/health insurance: _____

Life insurance: _____

Other monthly expense: _____

Total monthly expenses: $ _____

Cash/savings/checking accounts: _____

Stocks/bonds/investments/CD(s): _____

Other real estate/secondary residence: _____

Boat/RV/motorcycle/recreational vehicle: _____

Collector automobiles/non-essential automobiles: _____

Health savings/Flexible Spending Account: _____

I authorize AdventHealth to obtain information from external credit reporting agencies. 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 my medical bills. I understand that the information provided may be verified by ADVENTHEALTH, and I authorize AdventHealth 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 bill(s).

Signature of Applicant: _____

Date: _____

Comments: _____

Letter of Support

Patient medical record number or account number: _____

Supporter's name: _____

Relationship to patient or applicant: _____

Supporter's address: _____

To AdventHealth: _____

This letter is to advise that (patient's name): receives little or no income and I am assisting with this person's living expenses. This person has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter: _____

Date: _____

Dear Patient or Applicant,

AdventHealth is driven by compassion and dedicated to providing personalized care for all — especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergencies and other medically necessary care. Thank you for trusting us to care for you and your family for your health care needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for six months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of three most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or pension retirement award
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and is under the age 25
- Other income validation documents
- Copies of bank statements from last three months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with family or friends, please have them complete the attached form labeled Letter of Support. This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy and drug costs.

The completed application, along with proof of income, must be received for the application to be considered. We are unable to process or consider incomplete applications.
Please keep in mind that email communications over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by parties other than the person to whom it is addressed.
We want to protect your personal information and ensure that it remains secure. Since the application contains your Social Security Number and other private information, we urge you to refrain from emailing it.

Please print and mail your completed application to the following address:

AdventHealth
Attn: Financial Assistance
PO Box 935979
Atlanta, GA 31193

If you have any questions about this application, please call one of our financial counselors at 800-462-0490.

Sincerely,

Patient Financial Services AdventHealth