

Rush North Shore Medical Center Charity Care

Patient Name _____

Today's Date _____

Date of Service _____

Pt. Account Number _____

Rush North Shore Medical Center recognizes and acknowledges the financial burden on patients and families who are unable to afford their hospital bill. In keeping with our commitment to our customers, we offer charity care based solely on financial need.

Requirements for Charity Care Consideration

We need your cooperation with the hospital in exhausting all other forms of potential payments, including application for Public Assistance, if applicable, before being considered for charity care. We ask for the following documents:

- Most recent year's W-2
- Most recent Federal tax return form, including all schedules
- If income level has changed from previous tax return form, provide documents that support the change (i.e. copy of unemployment checks)
- Last 3 months bank statements
- Last 3 take home pay stubs
- Number of family members and dependents
- Copy of passport, if not a citizen
- No income: Provide signed letter explaining daily living support.

Failure to provide all required documents will result in denial of application until all requested information is received.

We will consider both the income you earn and the assets you own to determine if you qualify for Charity Care.

a. Income Criteria

Following review of your income information, we may offer discounts based on a sliding scale, which uses 200% of the Income Poverty Guidelines established by the U.S. Department of Health and Human Services. The department updates these guidelines annually.

b. Asset Criteria

We will use the information on the application and the documentation you provide to determine if you have assets available to help pay for your care.

Guidelines

1. Charity Care application only applies to the hospital and DOES NOT include physician bills. (Examples: Emergency Room Physician, Radiologist, Anestheologist, Pathologist etc..)
2. Hospital service must be medically necessary.
3. Patient does not qualify for Public Assistance and meets criteria for charity care.
4. First uses all available insurance.
5. Cooperates in making information available.
6. Provides evidence that he/she meets the guidelines. The hospital will run your credit report to verify your information

Should you have any questions or need assistance, please contact Customer Service at 847-933-6721. Customer Service is located in the main lobby of the hospital at Central Registration. We are available from 9:00am-4:00pm, Monday through Friday.

Effective 3/07

RUSH NORTH SHORE MEDICAL CENTER
Request for Charity Care
Patient Financial Statement

Patient Name _____ Patient Acct Number _____

Date of Service _____ Patient Portion _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ TELEPHONE NO. _____

CITY _____ STATE _____ ZIP CODE _____

MARITAL STATUS: S M W D _____ NAME OF SPOUSE _____

SOCIAL SECURITY # _____ SPOUSE SOCIAL SECURITY # _____

EMPLOYER _____ SPOUSE EMPLOYER _____

ADDRESS _____ ADDRESS _____

CITY _____ TEL # _____ CITY _____ TEL # _____

NUMBER OF DEPENDENTS ____ (as stated on IRS Statement)

INCOME: Attach supporting documents: last three pay stubs, copy of last income tax return form (including all schedules), copy of check if receiving Social Security, Pension, Unemployment, or Public Aid, interest on savings, three months of bank account statements, and copy of passport (for non-citizens). If no income, provide signed letter explaining daily living support.

I hereby authorize representatives of Rush North Shore Medical Center to make all necessary inquiries to verify the information furnished on this form, up to and including a credit report. I hereby state to the best of my knowledge the information given above is true and complete.

DATE: _____ SIGNATURE: _____

Please return completed application to:

Rush North Shore Medical Center
Attn: Judy Roszkowski, Mgr. Pt. Accts
9600 Gross Point Rd
Skokie, Illinois 60076

RUSH NORTH SHORE MEDICAL CENTER
Request for Charity Care
Financial Data

Previous Year Federal Income Tax Exemptions:
(Attach a copy of previous year 1040 form)

Previous 12 Months

INCOME

Salary and Wages (before deductions)
For all family members in household \$ _____

Public Assistance \$ _____

Social Security \$ _____

Unemployment Compensation \$ _____

Strike Benefits \$ _____

Veterans Benefits \$ _____

Alimony \$ _____

Child Support \$ _____

Military Family Allotments \$ _____

Pension \$ _____

Insurance Payments \$ _____

Annuity Payments \$ _____

Dividend Income \$ _____

Interest Income \$ _____

Rental Income \$ _____

Royalties \$ _____

Income from Estates or Trusts \$ _____

Other (Please explain) \$ _____

RUSH NORTH SHORE MEDICAL CENTER
Request for Charity Care
Financial Data

ASSETS

Checking, Savings, Money Market Accounts	\$_____
Certificate of Deposit	\$_____
Stocks, Bonds, and other Securities	\$_____