

## **Financial Assistance Process and Application**

The Financial Assistance Policy (“FAP”), process and application may also be obtained from the hospital’s website under the Patients and Visitor’s tab.

Financial Assistance Applications or assistance in completing the application may also be requested by:

- Visiting the hospital’s Cashier Department
- Calling the Patient Financial Counselors (at 847) 360-6954 or (847) 360-4299

The application specifies certain information that is required to be submitted with the application. This information may be independently verified by Vista Medical Center (VMC) to ensure its completeness and accuracy.

Please return your completed application with your supporting documentation to:

Vista Medical Center  
Attn: Patient Financial Counselor Department  
1324 N. Sheridan Road  
Waukegan, Illinois 60085

Notice of approval or denial of an application shall generally be sent to the patient within 30 days of receipt of application.

Financial assistance will be denied if Medicaid or other health and welfare eligibility applications are refused by the patient, if VMC reasonably believes that the patient could qualify.

If your request for financial assistance is denied, you may file an appeal. Appeals must include an appeal letter from the patient or party with financial responsibility requesting re-evaluation. The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration.

Please return your appeal with your additional supporting documentation to:

Vista Medical Center  
Attn: Patient Financial Counselor Department  
1324 N. Sheridan Road  
Waukegan, Illinois 60085

## Financial Assistance Application

Vista Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name \_\_\_\_\_ Account Number \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

Social Security \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Sex \_\_\_ M=Male F=Female Do you own a home? Yes ( ) No ( )

Number of dependents filed on tax return: \_\_\_\_\_ Do you own other property? Yes ( ) No

( ) List Dependents:

Do you own automobiles? Yes ( ) No ( )

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Gender</u>
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<b>Household Banking Information</b>	Name _____	Balance _____
<b>Business Banking Information</b>	Name _____	Balance _____

<u>Wages/Income</u>	Monthly	Annual
Self Wages	_____	_____
Spouse Wages	_____	_____
Other Family Member Wages	_____	_____
Social Security	_____	_____
Unemployment Benefits	_____	_____
Retirement / Pensions	_____	_____
Alimony / Child Support	_____	_____
Military Family Allotments	_____	_____
Pensions	_____	_____
Income from Rent, Dividends, Interest	_____	_____
<u>Expenses</u>	Monthly	Annual
Mortgage / Rent	_____	_____
Utilities	_____	_____
Auto Loans	_____	_____
Hospital Bills	_____	_____
Telephone	_____	_____
Food	_____	_____
Credit Cards	_____	_____
Gasoline	_____	_____
Child Care	_____	_____
Other	_____	_____

**Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.**

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____	_____	_____
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>