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 ( )

Name	Relationship	Age	Gender

Household Banking Information **Name**_____ **Balance**_____

Business Banking Information **Name**_____ **Balance**_____

Wages/Income	**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		
Expenses	**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.

_____ _____ _____

Print Name **Signature** **Date**