VISTA HEALTH SYSTEM

Financial Assistance Application

Patient MRN:_____

Patient Account Number: _____

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:

Completing this application will help Vista Health System 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 Vista Health System.

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 Vista Health System determine whether you qualify for any public programs.

Please complete this form and submit it in person, by mail, by fax, or email along with requested supporting documents within 90 days following the date of discharge or receive outpatient care to apply for free or discounted care.

You acknowledge that you have made a good faith effort to provide all requested information in this application to assist Vista Health System in determining whether you are eligible for financial assistance.

Presumptive Eligibility Criteria:

Uninsured patients who meet the presumptive eligibility criteria (criteria listed below), individually or otherwise by virtue of the patient's family income, you do not need to complete portions of this application addressing the income, asset or expense information.

☐ Homelessness
☐ Deceased with no estate
☐ Mental incapacitation with no one to act on patient's behalf
☐ Medicaid eligibility, but not on date of service or for non-covered service

Select any of these programs below you are enrolled in:

☐ Women, Infants and Children Nutrition Program (WIC)
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Illinois Free Lunch and Breakfast Program
☐ Low Income Home Energy Assistance Program (LIHEAP)
☐ Community Based Medical Assistance Program
☐ Grant Assistance for Medical Services

Please complete this application (all sections) and sign the application Certification.

Patient Information

Patient Name (include middle name): _____

Patient Date of Birth: _____

Patient Address:

Street: _____

Apt./Unit: _____

City:_____

State: _____

Zip Code: _____

Patient phone numbers:

Home phone number:_____

Cell phone number: _____

Social Security Number:_____

Marital Status:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow or Widower

If you are divorced or separated: Is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement?

☐ Yes ☐ No

E-mail Address: _____

Employer Name: _____

Employer Address:

Street: _____

Apt./Unit:_____

City:_____

State: _____

Zip Code: _____

Patient Insurance Coverage:

Are you covered or eligible or any health insurance policy, including: international/travel, Marketplace, COBRA, Veterans' benefits, Medicaid or Medicare?

☐ Yes ☐ No

If yes, please provide the following:

Policyholder: _____

Insurer: _____

Policy Number: _____

Policyholder: _____

Insurer: _____

Policy Number: _____

Have you applied for Medicaid? We may require you to.

☐ Yes (awaiting approval) ☐ Yes, Not eligible ☐ No

Were you an Illinois resident when care was rendered by Vista Health System:

☐ Yes ☐ No

Is the treatment provided related to any of the following:

☐ Accident

☐ Crime

☐ Workplace Injury

☐ Other: _____

Spouse/Partner/Guarantor or Parent(s) of Minor Information:

Name (First, Middle, Last): _____

Date of Birth: _____

Relationship to Patient: _____

Social Security Number: _____

Address:

Street: _____

Apt./Unit: _____

City:_____

State: _____

Zip Code: _____

Home phone number: _____

Cell phone number: _____

Employer Name: _____

Employer Address:

Street: _____

Apt./Unit: _____

City:_____

State: _____

Zip Code: _____

Family/household information:

Number of people in your family/household (as reported on your taxes): _____

List Dependents of Patient:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Gross Monthly Family Income: includes cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is guarantor for a minor.

Acceptable family income documentation shall include any "one" of the following:

A) a copy of the most recent tax return;
B) a copy of the most recent W-2 form and 1099 forms;
C) copies of the 2 most recent pay stubs;
D) written income verification from an employer if paid in cash; or
E) one other reasonable form of third-party income verification deemed acceptable to the hospital

Wages; _____

Self-employment; _____

Unemployment Compensation; _____

Social Security; _____

Social Security Disability; _____

Veterans' pension; _____

Veterans' disability; _____

Private disability; _____

Workers' compensation; _____

Temporary Assistance for Needy Families; _____

Retirement income; _____

Child support, alimony or other spousal support; _____

Other income; _____

Asset and estimated Asset Value Information: Please list the total balance for each of the following:

- Checking/Savings/Credit Union Accounts: $ _____ ☐ N/A
- Stocks/Certificates of Deposit/Mutual Funds: $ _____ ☐ N/A
- Health Savings/Flexible Spending Account $ _____ ☐ N/A
- Automobiles or other vehicles $ _____ ☐ N/A

Property:

Please provide information about any property such as buildings or land that you own **other than your primary residence.**

- 1) What is the value of all buildings and land minus the amount you owe on the property?
  $ _____ ☐ N/A
- Is this property used to make money? ☐ Yes ☐ No

- 2) What is the value of the land (without buildings) minus the amount you owe on the property?
  $ _____ ☐ N/A
- Is this property used to make money? ☐ Yes ☐ No

Monthly Expense Information:

Please list your monthly expenses below (the amount and also the frequency: weekly, biweekly, monthly, and if other (please specify)

Housing/Mortgage/Rent

Amount $: _____ Frequency: _____

Utilities (Electric, Heating/Air Conditioning, Water, etc.)

Amount $: _____ Frequency: _____

Food

Amount $: _____ Frequency: _____

Transportation

Amount $: _____ Frequency: _____

Dependent Care

Amount $: _____ Frequency: _____

Loans

Amount $: _____ Frequency: _____

Medical Expenses

Amount $: _____ Frequency: _____

Other expenses

Amount $: _____ Frequency: _____

Application 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 Vista Health System bill. I understand that the information provided may be verified by Vista Health System, and I authorize Vista Health System 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 grant to me may be reversed, and I will be responsible for the payment of Vista Health System bill.

Applicant Signature: _____ Date: _____

☐ Spouse ☐ Partner ☐ Parent/Guarantor (Select one when applicable-signature below)

Signature: _____

Submit completed Applications by:	Need Assistance? We can help.
Mail to: **Vista Health System** Attn: Patient Financial Counselor Department 1324 N. Sheridan Rd. Waukegan, Illinois 60085 **Fax:** (847) 782-4410 Email: VSAFinancialAssistance@amhealthsystems.com OR Contact the financial counselor at Vista Health System	**Call the Patient Financial Counselor at** (847) 360-4299 or visit the financial counselor at Vista Health System

Complaints or concerns with the uninsured patient discount application process may be reported to the Health Care Bureau of the Illinois Attorney General. You can contact them at 1-877-305-5145.