St. Bernard Hospital
and Health Care Center
326 West 64th St, Chicago, IL 60621
Tele 773.962.3900 Fax 773.602.3849

Charity Assistance Application – Hospital Services *Only*

PLEASE COMPLETE BOTH PAGES

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help St. Bernard Hospital determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please submit this application to the hospital. If you are uninsured a Social Security Number is not required for free or discounted care. However, a Social Security Number is required for some public programs including Medicaid and will help the hospital determine whether you qualify for any public programs.

Instructions: Please complete application,sign and return by mail, email, or by fax within 60 days of discharge/service date.

Patient information

Last name	First name	Birth date	Social Security number		
Street	**Apt number**	**City**	**State**	**Zip**	**Home phone**
Employer	**Employer's address**		**Work phone**		**Cell phone**
City	**State**		**Zip**	**Position**	

Spouse/Parent information (if patient is a minor)

Last name	First name	Birth date	Social Security Number		
Street	**Apt number**	**City**	**State**	**Zip**	**Home phone**
Employer	**Employer's address**		**Work phone**		**Cell phone**
City	**State**		**Zip**	**Position**	

Income information Attach copies of proof of family income, including but not limited to, paycheck stubs, benefit statements, award letters, federal tax returns or proof of any other income

Please list all income below. Include spouse's income, rental income, Social Security, unemployment compensation, worker's compensation, veteran's payments, insurance or annuity income, dividends, etc. Attach an additional sheet if more lines are needed. Provide copies of last pay stub, or income records, and most recent federal tax return with W–2s.

Income Received Monthly Gross Family Income **Gross amount**

Received from List source and amount **Link card received** ☐ Yes ☐ No

Monthly Expenses If the patient and/or the guarantor meets the presumptive eligibility based on income, the expenses information is not required.

Rent/mortgage: **Utilities:**

Medical expenses: **Food:** **Child Care:**

Transportation: **Other Expenses (please identify):**

Health Insurance information: Does the patient have health insurance ☐ Yes ☐ No

If YES, please provide the following information

Insurance name	**Insured policy number OR Recipient ID Number**
Insured name and date of birth	**Relationship to patient**

Were services received a result of a motor vehicle accident, a liability accident (such as a fall on personal/private property or victim of a crime? ☐ Yes ☐ No

Assets

Checking account balance: **Savings account balance:**

CDs: **Mutual funds:** **Automobiles/vehicles:**

HSA/FSA: **Stocks:**

Patient Name _____

Number of members in household _____

Please identify the number and ages of any dependents

Name	Age

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 this hospital bill. I understand that the information provided may be verified by St Bernard Hospital, and I authorize the hospital 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, and any financial assistance granted to me may be reversed and I will be responsible for the payment of the hospital bill.

_____ _____

Patient/Guarantor signature Date