Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE FROM SRALAB OR PHYSICIANS EMPLOYED DIRECTLY BY SRALAB.
Completing this Financial Assistance Application ("Application") will help Shirley Ryan AbilityLab ("SRAlab") determine if you can receive free or discounted services, or if there are other public programs that may be able to help pay for your healthcare.
Please note that Financial Assistance is only available to residents of Illinois.
If we determine that your Application is incomplete, we will request additional information and will provide you with thirty (30) calendar days to submit it.

By signing and submitting this Application, you acknowledge that you have made a good faith effort to provide all information requested to assist SRAlab in determining whether you are eligible for financial assistance, and you agree to communicate any change in financial situation within thirty (30) calendar days of a change.

For purposes of this Application, "you" refers to the patient, even if someone else is completing the Application on the patient's behalf.

PATIENT INFORMATION		
Patient's Name	Patient's Social Security Number	Patient's Date of Birth
Patient's Phone Number	Patient's Home Address	
Patient's Employer	Patient's Employer Address	Patient's Monthly Income

PATIENT INFORMATION - OPTIONAL		
This section is optional. A patient's responses or non-		

Phone Number	Guarantor's Address	
Guarantor's Employer	Guarantor's Employer Address	Guarantor's Monthly Income

PATIENT INSURANCE INFORMATION

Please mark an X below if the patient is covered under (or is a beneficiary of) any of the following health insurance programs:

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Is treatment provided related to any of the following:

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PRESUMPTIVE ELIGIBILITY CRITERIA

The information you provide on this section will help SRAlab determine if you are presumptively eligible to receive financial assistance. If you meet more than one criteria below, you only need to provide supporting documentation for one of the criteria you meet.

Criteria	Circle Yes / No	Include this Supporting Information with Your Application
Women, Infants, and Children Nutrition Program (WIC) Enrollment	Yes / No	A copy of any document, such as a letter, that shows that the patient is receiving such assistance.
Supplemental Nutrition Assistance Program (SNAP) Enrollment	Yes / No	
Illinois Free Lunch and Breakfast Program Enrollment	Yes / No	
Low Income Home Energy Assistance Program (LIHEAP) Enrollment	Yes / No	
Receipt of grant assistance for medical services	Yes / No	
Medicaid eligible, but not on date of service or for non-covered services	Yes / No	None needed. We will check state databases to confirm.
Deceased with no estate	Yes / No	A copy of the patient's death certificate
Mental incapacitation with no one to act on patient's behalf	Yes / No	Written statement from patient's physician or family
Community-based program enrollment	Yes / No	A letter from the program that certifies the patient's membership
Recent personal bankruptcy	Yes / No	Legal documentation indicating recent bankruptcy
Homeless	Yes / No	Shelter address: _____ _____ _____ Shelter phone number: (_____) _____
Incarceration	Yes / No	

HOUSEHOLD INCOME

(To be completed only if you did not meet any of the presumptive eligibility criteria listed above)

3. Household Income Verification: Please provide the following documents, as applicable:
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   - D}•š Œ -2 and 1099
   - dÁ} ~î• u}•š Œ v š]v }u •šµ and/or unemployment benefits Z l•
   - Employer's written verification of income, if paid in cash
   - Business or retirement/pension income (if not reflected on most recent tax return, or if current year's amount will vary from that reflected in most recent tax return)

4. Assets: Please provide the following documents, if applicable:
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   - /v(}Œ u š]}v Œ P Œ]v P À o µ }(U v]v }u Œ] À (Œ}uU }Á v ‰ Œ}‰ residence
   - K š Z Œ]v À •šu v š]v(}Œ u š]}v ~ }v •U •š} l•U š X U• other than the amounts held in IRA/401k retirement and 529 college savings accounts

PATIENT CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any stat 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 the 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