



Thank you for choosing *Advocate* as your health care provider. *Advocate Health Care* strives to provide quality health care to meet the needs of the community it serves.

If you would like information about financial assistance and payment options that may be available to you, including payment plans and charity care consideration, you may fill out the attached Charity Assistance application and return it to us with the following information:

- Last pay stub (or, if applies, copy of unemployment statement, Social Security Award Letter, etc.)
- Most current federal tax return with W-2
- Copies of checking, savings, account statements (past 3 months)
- You *may provide* additional documents to show extenuating circumstances that could be affecting your financial situation, and may assist in our evaluation, such as: medical bills, loans, rent, mortgage, utility bills.

Please call us if you have questions or need assistance. Return your completed application and documents to the hospital at the following address:

Advocate Good Shepherd Hospital
450 West Highway 22
Patient Accounts Department
Barrington, IL 60010

(847) 842-4877

Charity Assistance Application – *Hospital Services Only* Patient Account Number(s):

Instructions: Complete the application in full and sign the authorization to verify information.

Patient Information

Last Name	First	M.I.	Age	Social Security No.	Dependents
Street	Apt #	City	State	Zip Code	Home Phone
Employer	Address				Cell Phone
City	State	Zip Code	Position	Work Phone	
Primary Bank Name (Guarantor)	Address		City	State	

Spouse/Parent Information (if Minor)

				Relationship to Patient	Age
Last Name	First	M.I.	Social Security No.		Cell Phone
Employer	Address				Work Phone
City	State	Zip Code	Position		

Income Information

List all income - 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-2's.**

Description of Income	Paid To	Gross Amount
___ Weekly ___ Bi-Weekly ___ Monthly		
___ Weekly ___ Bi-Weekly ___ Monthly		

Assets/Additional Income	Monthly Expenses	Enter Amount
<ul style="list-style-type: none"> Savings/Checking Accounts Provide copies of last 3 statements 	Mortgage/Rent (circle)	\$
<ul style="list-style-type: none"> Recent federal tax return with w-2's Provide 1 copy 	Loan(s)	\$
<ul style="list-style-type: none"> Stocks, Bonds, Mutual Funds, Other Provide copies of most recent statements 	Prescriptions/Medical	\$

Attach copies of any outstanding medical bills, utility bills, or extraordinary expenses you would like us to consider. Please provide any additional information that may assist us in assessing your financial situation on the back of this form or on a separate sheet of paper.

Support Statement

If you reported \$0.00 income above, please have the section below completed by the person(s) helping you.

I have been identified by the applicant as providing room and board, but I am not responsible for payment of his/her medical bills.

Print Name _____ No. of Months providing Room and Board to Patient _____
Signature _____ Relationship to Patient _____

Please attach proof of residency, such as a utility bill, with your current address on it.

Patient/Guarantor Statement: I certify that the above information is true and complete to the best of my/our knowledge. Applicant(s) authorize Advocate Health Care to check my/our address, employment and credit history.

Patient/Guarantor Signature _____

Date _____