Advocate Health Care

Hardship Discount Application

Hardship Overview

The information requested in this application is required to determine eligibility for a Hardship Discount. The Hardship Discount program is for insured or uninsured patients who are over the income limit for Financial Assistance. Eligibility is based on balances due for services received at Advocate Health Care in comparison to the patient's household income.

Requirements to Apply for the Hardship Discount

To be considered for the Hardship Discount, the patient must meet the following requirements:

- Resident of Illinois
- The patient must fully cooperate with the Hardship review process. If additional information and/or proof documents are needed to complete the application, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information requested is not received by the deadline, the patient will not be eligible.

What to Expect: The Eligibility Review Process

Eligibility will be determined in a timely manner from the date the application is received by the Financial Assistance Services Team at Advocate Health Care. Once the eligibility review is complete, a letter will be mailed to the patient to let them know if they have been approved or denied.

Please complete all 3 pages of this form. Filling out this form completely will help to prevent delays in the review process.

Patient Information			
Patient Name	Social Security#	Date of Birth	Account#

Applicant Information				
Applicant Name	Relationship to Patient	Social Security#	Date of Birth	Marital Status
Address		City, State and Zip Code		

Home Phone#	Cell Phone#	Emergency Contact Name	Emergency Contact Phone#
Employer Name		Employer Address	Work Phone

NOTE: If the address where you receive mail is different from the address where you live, please fill out the 'mailing address' information below

Mailing Address	City, State and Zip Code

Health Insurance Information ☐ Check this box if the patient does not have any source of health insurance coverage				
Health Insurance Provider	Policy Holder Name	Policy#	Group#	Effective Date

Has a member of the household lost their job within the past 60 days?	☐ Yes ☐ No
Did he/she receive a COBRA election notice?	☐ Yes ☐ No
Did he/she elect COBRA coverage?	☐ Yes ☐ No
If he/she did not elect COBRA coverage, please check one: ☐ COBRA premiums too expensive ☐ has new coverage	

Please list all household members below

	Name	Social Security#	Date of Birth	Relationship to Patient
1				
2				
3				
4				
5				
6				

NOTE: Please list any additional members of the household in the 'notes' section on page 3 of this form

Monthly Household Income

Type of Income	Monthly Gross Income for Applicant	Monthly Gross Income for Applicant's Spouse
Employment Income	$	$
Retirement/Pension/Social Security Retirement	$	$
Social Security Disability Income	$	$
Unemployment Income	$	$
Child Support/Alimony	$	$
Other (list source here_____)	$	$

Statement of Support

I certify that I have been unemployed for the last_____years /_____months. As a result of being unemployed, I receive food, shelter and clothes from_____(relationship to applicant =_____)

Acknowledgement and Signatures

I hereby certify that the information provided in this application is true, accurate and complete to the best of my knowledge. I hereby authorize the Hospital to contact any person, firm or organization to verify any of the information given and I hereby authorize any such person, firm or organization to release to the Hospital any financial information it may request.

Applicant Signature Date

Mail Completed Application to:

Advocate Health Care

Attention: Financial Assistance Services

PO Box 3039

Oak Brook, IL 60522-9908

Notes