INSIGHT
HOSPITAL & MEDICAL CENTER

2525 S Michigan Ave.
Chicago, IL 60616-2477

Financial Assistance Application

PATIENT NAME:	**Insight Hospital & Medical Center Chicago** 2525 S Michigan Ave. Chicago, IL 60616-2477 PHONE: 312-567-2372 FAX: 312-567-7904
PATENT #:	
MEDICAL RECORD #:	

I. RESPONSIBLE PARTY

LAST NAME	FIRST NAME	MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS				

CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?	HOME PHONE	CELLULAR PHONE

EMPLOYER'S NAME AND ADDRESS	BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE	MONTHLY INCOME	PAY PERIOD

II. SPOUSE

NAME		SOCIAL SECURITY #
EMPLOYER'S NAME AND ADDRESS	BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE	MONTHLY INCOME	PAY PERIOD

III. HOUSEHOLD INFORMATION (ALL PERSONS IN HOUSEHOLD)

NAME	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP

TOTAL PERSONS IN HOUSEHOLD:

IV. OTHER MONTHLY INCOME			
DIVIDENTS, INTEREST	$	PENSIONS	$
PUBLIC ASSISTANCE/FOOD STAMPS	$	INVESTMENT/RENTAL INCOME	$
SOCIAL SECURITY	$	GRANTS	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	OTHER	$
CHILD SUPPORT/ALIMONY	$		
TOTAL OTHER MONTHLY INCOME:	**$**		

V. MONTHLY EXPENSES			
RENT/MORTGAGE	$	FOOD	$
HOMEOWNER'S INSURANCE	$	CLOTHING	$
PROPERTY TAX	$	CAR PAYMENTS	$
ELECTRIC	$	CAR INSURANCE	$
WATER	$	GASOLINE	$
TELEPHONE/CELLULAR PHONE	$	ALIMONY/CHILD SUPPORT	$
LOANS	$	CREDIT CARDS	$
MEDICAL INSURANCE	$	MEDICATIONS	$
LIFE INSURANCE	$	OTHER (Specify)	$
TOTAL MONTHLY EXPENSES:	**$**		

VI. MONTHLY EXPENSES		
RESPONSIBLE PARTY'S MONTHLY INCOME		$
SPOUSE'S MONTHLY INCOME (If Applicable)	+	$
TOTAL OTHER MONTHLY INCOME	+	$
TOTAL MONTHLY EXPENSES	-	$
TOTAL MONTHLY EXPENSES:		**$**

VII. ASSETS		REAL ESTATE/VEHICLES/RECREATION (Equity Value)	
CHECKING ACCOUNT(S)	$	REAL ESTATE PROPERTY	$
SAVINGS ACCOUNT(S)	$	MOTORHOME(S)	$
INVESTMENTS/IRA'S	$	BOAT/TRAILER(S)	$
CD'S	$	AUTOMOBILE(S)	$
TOTAL ASSETS	**$**		

If unable to provide requested documents, please explain below. Use additional pages if needed.

I declare that the answers I have given are true and accurate.

I understand that I may be asked to prove any statements and my eligibility statements will be subject to verification by contact with my employer, and bank credit cerification. I also authorize and instruct any person or consumer-reporting agency to furnish Insight Hospital & Medical Center Chicago any information that it may have or obtain in response to such financial inquiries.

I understand that Insight Hospital & Medical Center Chicago is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of any accident or injury, to reimburse the hospital from the proceeds of litigation or settlement resulting from such an act.

_____

Signature of Reponsible Party

_____

Date

Please send the application and all supporting document(s) required within sixty (60) business days.

*** INCOMPLETE APPLICATIONS MAY NOT BE PROCESSED ***

Mail to: Insight Chicago Hospital and Medical Center
Attention: Financial Counseling Ofice
2525 S. Michigan Ave
Chicago, IL 60616-2477

Should you have questions or need help completing the application, please contact the Patient Financial Services Department to speak with a financial Counselor at the phone number listed below.

Patient Financial Service Department: 312-567-2372