

**THE UNIVERSITY OF CHICAGO MEDICAL CENTER  
APPLICATION FOR FINANCIAL ASSISTANCE**

Date: \_\_\_\_\_ Medical History # \_\_\_\_\_

**Patient Name** \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ Last four digits of SSN \_\_\_\_\_

Marital Status (circle one): S M W DIV SEP # of Dependents & Ages: \_\_\_\_\_

Account No.(s) \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ Last four digits of SSN \_\_\_\_\_

Marital Status (circle one): S M W DIV SEP Relationship to Patient: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last four digits of SSN: \_\_\_\_\_ # of Dependents & Ages: \_\_\_\_\_

**MONTHLY INCOME**

<b><u>OCCUPATION</u></b>	<b><u>INCOME</u></b>
Patient _____	_____
_____	_____
Responsible Party _____	_____
Other/Spouse _____	_____
	<b>Total</b>

**ASSETS**

Savings Account(s) Balance(s): \_\_\_\_\_ Checking Account Balance(s) \_\_\_\_\_

Stocks, bonds, CD, money market balance(s) \_\_\_\_\_ Other Account(s) Balance(s) \_\_\_\_\_

If you own any of the following items, please list the type and approximate value. **VALUE**

Secondary Home/Vacation Home	_____
Automobile	_____
Additional Vehicle(s) (make/year)	_____
Other property	_____
	<b>Total</b>

**Patient Inquiry Representative** \_\_\_\_\_

PLEASE ALSO COMPLETE PAGE 2 OF APPLICATION FORM

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**MONTHLY EXPENSES:**

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Food _____	_____
Utilities _____	_____
Auto/Gas _____	_____
Telephone _____	_____
Clothing _____	_____
Child Care _____	_____
Other _____	_____
	<b>Total</b>

**CREDITORS**

<u>DESCRIPTION</u>	<u>AMOUNT</u>
Rent/Mortgage _____	_____
Medical/Doctor _____	_____
Medical/Hospital _____	_____
Medical/Other _____	_____
Insurance/Auto _____	_____
Insurance/Life _____	_____
Insurance/Health _____	_____
Credit Card _____	_____
Credit Card _____	_____
	<b>Total</b>

**TOTAL MONTHLY INCOME**

**PLUS ASSETS OVER \$1,000** \_\_\_\_\_ (+)

**AVAILABLE CONTRIBUTION** \_\_\_\_\_ (=)

I hereby certify that the information that I have furnished above is true and correct to the best of my knowledge. Should my circumstances change, I hereby agree that I will immediately notify The University of Chicago Medical Center at (773) 702-6664. I understand that, by my signature below, I authorize UCMC and/or its affiliates and designees to access records from various credit requesting bureaus.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**Required Documents:**

- Most recent year's tax return and W2
- Prior year's tax return and W2
- Copy of Drivers License or State ID
- Copy of Medicaid Denial Letter
- SSA 1099 Form (if applicable)
- Verification of Additional Income

**Return Completed Application to:**

The University of Chicago Medical Center  
Patient Financial Services  
MC1086, 8201 South Cass Avenue  
Darien, Illinois 60561

**Patient Inquiry Representative** \_\_\_\_\_

09/17/07