South Shore Hospital
Financial Assistance/Charity Application

Date: _____/_____/_____

Patient Name:_____ Date Of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip Code: _____ Account #: _____ Balance: $_____

Spouse/Parent Name: _____
Phone #: Home: (____)_____Cell: _____
Responsible Person: _____
Employer: _____
Spouse's Employer: _____
Number Of Members In The Family: _____
Marital Status: _____

Alleged Accident: _____
Illinois Resident: _____
Citizenship (please check)
U.S. Citizen _____
Immigrant/Non-Citizen _____
Non-Immigrant Visa Holder _____
Other: _____

Other Income Including – SSI/Social Security/Child Support Payments: _____
Who Receives Income: _____ Source: _____ Gross Amount: $ _____

Please list all household members including minor children under 21 who lives with you (even if they are not applying for Financial Assistance at this time).

First And Last Name	Age	Relationship	Medical Insurance	Citizenship

Monthly Family income

Total Household: $ _____
SSI: $ _____
Disability: $ _____
Child Support: $ _____
Retirement: $ _____
Unemployment: $ _____
Other: $ _____

TOTAL: $ _____

Medical Insurance

Yes _____ No _____
Type: _____
Ins. Co. : _____
I.D. # _____

Monthly Expenses

House/Rent $ _____
Utilities: $ _____
Gas: $ _____
Electric: $ _____
Phone: $ _____
Food: $ _____
Medical Expenses: $ _____
Outstanding Loan: $ _____
Child Care: $ _____
Other: $ _____

TOTAL: $ _____

Asset Information

Checking: $ _____
Savings: $ _____
Stocks/Bonds: $ _____
Certificates: $ _____
Property: $ _____
Automobiles: $ _____
Make: _____ Year: _____
Make: _____ Year: _____
Home: $ _____
Other: $ _____

TOTAL: $ _____

I understand that this application for Financial Assistance is confidential and will be used to determine my eligibility for uncompensated services under the Financial/Assistance guidelines established by South Shore Hospital. This application is for **Hospital Services Only.** I authorize the hospital to contact third parties to verify the accuracy of the information provided.

Signature: _____ Date: _____/_____/_____

If you have any questions about completing this form, contact the SSH Financial Counselor @ 773-356-5218

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* **PLEASE PROVIDE AND RETURN WITH COPIES OF THE FOLLOWING DOCUMENTS:**

- Three (3) current consecutive paystubs
- Federal Tax Return (This is not required, but helpful in making a determination of your application)
- Identification: Driver's License/Social Security Card/ Passport/Birth Certificate
- Letter of Support – If not employed
- Proof of expenses

*** Important: Producing the requested information will assist us in determining whether or not you can receive free or discounted services. Please complete the entire form and submit it back to the hospital within 30 days following the date of discharge or date of treatment for outpatient services.**

RETURN TO :
SOUTH SHORE HOSPITAL
BUSINESS OFFICE ATTN: FINANCIAL COUNSELOR
FINANCIAL ASSITANCE CHARITY PROGRAM
8012 SOUTH CRANDON AVE.
CHICAGO ILLINOIS 60617

Financial Assistance % Allowance	2019 Percent of federal Poverty Level	1 Person	2 Person	3 Person	4 Person	5 Person	6 Person
100%	**Federal Poverty Level (FPL)**	**$12,490**	**$16,910**	**$21,330**	**$25,750**	**$30,170**	**$34,590**
80%	**Up to 200%**	**$24,980**	**$33,820**	**$42,660**	**$51,500**	**$60,340**	**$69,180**
60%	**201 – 250%**	**$31,225**	**$42,275**	**$53,325**	**$64,375**	**$75,425**	**$86,475**
40%	**251 – 300%**	**$37,470**	**$50,730**	**$63,990**	**$77,250**	**$90,510**	**$103,770**
20%	**301 – 400%**	**$49,960**	**$67,640**	**$85,320**	**$103,000**	**$120,680**	**$138,360**
0 over 401%							
	Each additional household member add $4,320						

FOR HOSPITAL USE ONLY:

Date Received: _____/_____/_____

Account Number: _____

Approved By: _____

Reason: _____

Processed On: _____/_____/_____

Rejected By: _____

Amount Granted: _____

Balance Due: _____

Patient Notified: Yes_____ No_____