Swedish Covenant Medical Group

FINANCIAL ASSISTANCE PROGRAM

Thank you for choosing Swedish Covenant Medical Group for your health care needs. We offer financial assistance to help people of limited financial means. Completing this application will help Swedish Covenant Medical Group determine if you can receive free or discounted services. Information about your income and family size are important in determining if you are eligible.

Please complete the attached application and include required documents listed below*:

- Valid government issued photo ID (driver's license, state ID, passport, etc.).
- Most recent federal tax return, with all W-2 forms or 1099.
- Proof of Income (provide all applicable listed below):
  - Copies of 2 most recent paystubs.
  - If paid in cash written verification of income from employer.
  - Self-employed: Submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility.
  - Unemployment compensation benefit award letter.
  - Social Security benefit award letter.
  - All other sources: Child support, disability, rental, pension, annuities, interest, etc.
- Copies of two most recent bank statements; include all checking and savings accounts.
- Self-declaration of income: If you report $0.00 income a completed self-declaration of income, attached at the end of the application, signed by the person(s) supporting you.

***If married, copies of income and bank statements are required from your spouse.**

Your application will be delayed or denied if all required documentation is not included.

Please return your application within 14 days of receipt.

Swedish Covenant Medical Group
Attn: Patient Financial Services
2740 W. Foster Ave Suite 001
Chicago, IL 60625

If you need help completing your application or have questions, please contact our Patient Financial Services Team toll free at (866) 484-1841 or locally at (773) 243-2584.

Swedish Covenant Medical Group

FINANCIAL ASSISTANCE APPLICATION

(PLEASE PROVIDE ALL REQUESTED INFORMATION)

NOTE: This application is for Swedish Covenant Medical Group providers only.

Date of Application ____/____/____

PATIENT INFORMATION			
Last Name	**First Name**	**M.I.**	**Date of birth** ___/___/___

APPLICANT/GUARANTOR INFORMATION (if applicant is a minor)			
Last Name	**First Name**		**M.I.**
Date of Birth __/__/__	**Social Security #** - -		
Address	**City**	**State**	**Zip**
Phone # ( ) -	**Marital Status** ☐ Single ☐ Married ☐ Separated ☐ Divorced		
Employment Status ☐ Employed ☐ Self-Employed ☐ Disabled ☐ Retired ☐ Unemployed Since __/__/__			
Employer	**Occupation**		**Date of hire** ___/___/__
Employer Address	**City**	**State**	**Zip**
Phone # ( ) -	**Does employer offer health insurance?** ☐ Yes ☐ No		
Hours Worked Weekly	**Income** ☐ Hourly ☐ Salary **Amount $**		
Other Income Source	**Amount $**	**Frequency**	

SPOUSE/PARTNER INFORMATION (if applicable)			
Last Name	**First Name**		**M.I.**
Date of Birth ____/____/____	**Social Security #** - -		
Address	**City**	**State**	**Zip**
Phone # ( ) -	**Marital Status** ☐ Single ☐ Married ☐ Separated ☐ Divorced		
Employment Status ☐ Employed ☐ Self-Employed ☐ Disabled ☐ Retired ☐ Unemployed Since ____/____/___			
Employer	**Occupation**		**Date of hire**____/__/___
Employer Address	**City**	**State**	**Zip**
Phone # ( ) -	**Does employer offer health insurance?** ☐ Yes ☐ No		
Hours Worked Weekly	**Income** ☐ Hourly ☐ Salary **Amount $**		
Other Income Source	**Amount $**	**Frequency**	

TOTAL DEPENDENTS		
Name	**Date of Birth**	**Relationship**

MONTHLY EXPENSE INFORMATION (if applicable)			
Housing ☐ Rent ☐ Own	$	**Heat / Utilities**	$
Food	$	**Transportation**	$
Loans	$	**Phone / Cell Phone**	$
Cable TV / Internet	$	**Insurance**	$
Child Care	$	**Child Support**	$
Credit Cards	$	**Car Payment**	$
Medical Bills	$	**Other**	$
TOTAL EXPENSES	$		

CERTIFICATION

I certify that the information on this application is true and correct. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for payment of my bill.

Applicant Signature _____ Date_____

Self-declaration of income (If reporting $0.00 income)			
The applicant is reporting a $0.00 income. The type of support I/we provide is below.			
☐Room/Board Since ____/____/____		☐Allowance $_____ every (day/week/month)	
Other support provided			
Last Name		**First Name**	**M.I.**
Phone #	**Relationship**		
Last Name		**First Name**	**M.I.**
Phone #	**Relationship**		

I certify that I/we have been the sole/substantial support for the applicant. To the best of my/our knowledge the applicant has no other means of support. I/we will continue to provide support at our discretion but will not be responsible for medical expenses incurred.

Support Signature #1_____ Date_____

Support Signature #2_____ Date_____