

**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

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

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	_____
	Total

Patient Inquiry Representative _____

PLEASE ALSO COMPLETE PAGE 2 OF APPLICATION FORM

**THE UNIVERSITY OF CHICAGO MEDICAL CENTER
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MONTHLY EXPENSES:

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

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 _____	_____
	Total

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