COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Application for CareLink

Information You Should Know

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Cook County Health & Hospitals System determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care with all the required verifications/documents within 90 days following the date of discharge or receipt of outpatient care.

JOHN H. STROGER JR. HOSPITAL
FINANCIAL ASSISTANCE OFFICE
1901 W. HARRISON AVE., ROOM 1690
CHICAGO, IL 60612
Phone Number: (866) 223-2817
FAX NUMBER: (312) 864-9136

OAK FOREST HEALTH CENTER
FINANCIAL ASSISTANCE OFFICE
15900 S. CICERO. BUILIDNG E
OAK FOREST, IL 60452
Phone Number: (866) 223-2817
FAX NUMBER: (708) 633-3427

PROVIDENT HOSPITAL
FINANCIAL ASSISTANCE OFFICE
OLD SENGSTACKE BUILDING, 1ST FLOOR
500 E 51ST
CHICAGO, IL 60615
Phone Number: (866) 223-2817
FAX NUMBER: (312) 572-2375

EMAIL: mycookcountyhealth.com

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

1. Patient Information

Name _____ _____ _____
Last First Middle

Date of Birth ____-____-____ Social Security Number (not required if uninsured) ____-____-____

Address_____Apt Number_____

City _____County _____State _____Zip Code _____

Home Telephone Number____-____-____Work Number ____-____-____Cell Number ____-____-____

Email address _____

Were you a Cook County Resident when care was rendered? _____

Were you involved in an alleged accident? _____

Were you a victim of an alleged crime? _____

2. Patient Guarantor (if applicable, may be patient's spouse, partner or the parent or guardian of a minor)

Name _____ _____ _____
Last First Middle

Address_____Apt Number_____

City _____County _____State _____Zip Code _____

Home Telephone Number_____-_____-_____Work Number _____-_____-_____Cell Number _____-_____-_____

3. PRESUMPTIVE ELIGIBILITY CRITERIA

Does any of the information below apply to you? If YES, check the ones that apply.
If you check any of these statements, please provide documentation/verification that you meet the criteria.

____ Homelessness

____ Deceased with no estate

____ Mental incapacitation with no one to act on patient's behalf

____ Medicaid eligibility, but not on date of service or for non-covered service

____ Recent personal bankruptcy

____ Incarceration in penal institution

____ Member of a religious order and vow of poverty

Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

____ Women, Infants, and Children Nutrition Program (WIC)

____ Supplemental Nutrition Assistance Program (SNAP)

____ Illinois Free Lunch and Breakfast Program

____ Low Income Home Energy Assistance Program (LIHEAP)

____ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financials statues as a criterion for membership

____ Receipt of grant assistance for medical services

Enrollment in the following assistance programs for low-income individuals:

____Temporary Assistance for Needy Families (TANF)

____Illinois Housing Development Authority's Rental Housing Support Program

4. HOUSEHOLD INFORMATION

Fill in the information below for all the members of your household (spouse and children).

Name (Last, First, Middle)	Social Security Number *(not required if you are uninsured)*	Relationship	Age

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5. INCOME

What is your monthly gross household income? $_____

Applicant's Employer	Address	Employer Phone #

Are you paid weekly_____, bi-weekly_____, twice a month_____ or monthly _____

Spouses Employer	Address	Employer Phone #

Is your spouse paid weekly_____, bi-weekly_____, twice a month_____ or monthly _____

Do you or your spouse, partner or the parent or guardian of a minor receive any of the following?

____Alimony support
___Social Security Disability
____Unemployment Insurance
____Worker's Compensation
____Regular cash support from family/others not living in the applicant household
____Farming income
____Dividends, interest and royalties
____Lump Sum Payments (Counted only if received more than one in year, and only counts in the month received)
___Social Security (Retirement, Widow/Widower)
___Supplemental Security Income (SSI).
___Pensions and annuities
___Veteran's Administration Benefits
___Child support payments
___Income from rental property
___Education/training stipends (specified for living expenses)
___Odd jobs such as babysitting, cleaning houses, or mowing lawns, and day labor

6. THIRD PARTY COVERAGE

Do you or your spouse have access to any type of health insurance coverage? _____Yes _____No

Have you applied for any state or federal assistance, Medicaid, Medicare, or SSI? _____Yes _____No if yes, provide the following information:

Who applied?	When?	Where?	Status?

Patient Certification

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. 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 the payment of the hospital bill.

_____ _____-_____-_____
Signature of Patient or Applicant Date