



Mr. (s) _____.

The following documentation is needed in order to process the Financial Assistance application for Saint Anthony Hospital. You have 10 business days from today _____ to return the requested documents. Please return copies of the requested documents within the time frame stated otherwise the application will be rejected.

- **Identification, only one is required :**
(Driver's license, Passport, SS card, Etc.)
- **Proof of income :**
A complete copy of the previous year's income tax returns.
Unemployment benefit checks (If recently unemployed)
Last 4 check stubs.
Social Security benefits letter (If retired)
Savings account balances.
- **Letter of support.** (If not employed)
- **Proof of dependents.** (if not listed on tax forms)
Birth Certificate, Social Security card or Identification.

If you have any questions please feel free to contact us at (773) 484-4800 from 8:30 AM to 3:30 PM or (773) 484-4083 3:30 PM to 10:30 PM Monday thru Friday.

**PLEASE MAIL ALL THE DOCUMENTATION TO:
SAINT ANTHONY HOSPITAL
P.O. BOX 809109
CHICAGO, ILLINOIS 60680-9109
ATTN: CUSTOMER SERVICE REP.**

SUBMIT VIA FAX TO (773) 484-4806

**PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL SERVICES ONLY.
YOU MAY RECEIVE A BILL FOR THE PHYCISIAN SERVICES.**

**SAINT ANTHONY HOSPITAL
FINANCIAL ASSISTANCE APPLICATION**

DATE: ____/____/____

RETURN WITHIN THE NEXT 10 BUSINESS DAYS

PATIENT NAME: _____ TELEPHONE: (____) ____-____

CURRENT ADDRESS: _____

VISIT ID NUMBER (S)

DATE OF SERVICE: ____/____/____ TO ____/____/____

PATIENT'S BALANCE DUE \$ MR#

Source of income Employed Disability Social Security
 Child Support Alimony Unemployment Compensation
 Other _____

Amount of total annual combined income: \$

Employer's Name: _____ Spouse's Employer Address: _____
 Address: _____ Address: _____
 Phone Number: _____ Phone Number: _____

Marital Status: Single Married Divorced

| Dependents | Name | Age | Social Security Number |
|------------------|------|-----|------------------------|
| Guarantor | | | |
| Dependent 1 | | | |
| Dependent 2 | | | |
| Dependent 3 | | | |
| Dependent 4 | | | |
| Dependent 5 | | | |
| Dependent 6 | | | |

ADDITIONAL COMMENTS:

IN THE SPACE PROVIDED BELOW, PLEASE PROVIDE ANY ADDITIONAL COMMENTS/INFORMATION WHICH MAY ASSIST IN OUR ASSESSMENT OF YOUR FINANCIAL SITUATION:

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENT(S) ARE TRUE. I AUTHORIZE SAINT ANTHONY HOSPITAL TO MAKE ANY INQUIRIES NECESSARY TO VERIFY THEIR ACCURACY.

PATIENT'S SIGNATURE _____ DATE _____

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| | |
|-----------------------------------|------------|
| HOSPITAL USE: APPROVED % _____ | Date _____ |
| DENIED/REASON _____ | Date _____ |



**Saint Anthony
Hospital**

Caring for the community

Letter of Support /
Carta de Sostenimiento

Date _____

Name (s) _____

Address _____

Phone # (s) _____

I/We provide room & board to _____

since (date) _____ to present.

Relationship to Patient _____

Signature (s) _____

Fecha _____

Nombre (s) _____

Dirección _____

Teléfono (s) _____

Yo/Nosotros le proveemos albergue y comida a _____

desde (fecha) _____ hasta el día de hoy.

Parentesco con el Paciente _____

Firma (s) _____
