Cancer Treatment Centers of America
part of City of Hope

CTCA Chicago Financial Assistance Evaluation Form

As part of our commitment to serve the community, CTCA elects to provide financial assistance to patients who are uninsured or underinsured and satisfy certain requirements.

Financial assistance is not considered to be a substitute for personal responsibility, and patient families are expected to cooperate by providing complete and accurate information so CTCA can determine a patient's eligibility for our financial assistance program, and to contribute to the cost of the patient's care based on individual ability to pay.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

To determine if a patient qualifies or financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Financial Assistance Application

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help CTCA Chicago 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 in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 240 days following the date of discharge or receipt of outpatient care. Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist CTCA in determining whether the patient is eligible for financial assistance.

State of Illinois Residents Only

IF YOU ARE UNINSURED AND DEMONSTRATE ONE OF THE SPECIFIC PRESUMPTIVE ELIGIBILITY CRITERIA LISTED BELOW, YOU ARE NOT REQUIRED TO COMPLETE THE APPLCATION. For questions on presumptive eligibility criteria, please contact Patient Accounts at 800-677-5545 Monday through Friday from 8:00am-4:00pm CST.

○ Homelessness	Enrollment in assistance programs for low-income individuals
○ Deceased with no estate	○ Women, Infants, and Children Nutrition Program (WIC)
○ Mental incapacitation with no one to act on patient's behalf	○ Supplemental Nutrition Assistance Program (SNAP)
○ Medicaid eligibility, but not on date of service or for non-covered service	○ Illinois Free Lunch and Breakfast Program (LIHEAP)
	○ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership
	○ Receipt of grant assistance for medical services

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Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Spouse Email _____

Med Record #: _____ Social Security #.: _____ Annual Household income: $ _____

Employer Info: _____

Does the patient have Health Insurance? YES ☐ NO ☐

Has the patient applied for Medicaid? YES ☐ NO ☐ If yes, when? _____

Is the patient on Social Security Disability? YES ☐ NO ☐

Additional Info: _____

Dependent Information

Number of Dependents: _____ Ages: _____

Spouse/Partner /Guarantor: _____ Employer: _____

Disclaimer and Signature

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: _____ Date: _____

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Additional Information

Additional Patient Information (Optional): Responses to these questions are OPTIONAL. Responses or choosing not to respond will not have any effect on whether patient is eligible for financial assistance.

Race/Ethnicity:	Sex:
Preferred Language:	

Completed forms may be:

1. Emailed to mailto:PtAccountsFinancialHardshipTeam@ctca-hope.com
2. Returned to the hospital financial counselors
3. Mailed to:

   CTCA – Patient Accounts
   2610 Sheridan Road
   Zion, IL 60099

- CTCA reserves the right to review a credit report for you and your spouse as needed.
- CTCA may ask for additional documentation including but not limited to W2's, Most Recent Tax Return, Social Security Statement, Proof of life changes, etc.
- CTCA may review accounts held for outstanding insurance payments that have been sent to the member

Once all information is received, CTCA will respond within 30 days to your request for financial assistance. Should we need additional information to process your request we will contact you via phone or email. You will be notified by mail of your eligibility once the application and all documentation is received and processed; standard collection procedures will continue until complete information is received.

For status or questions, please contact Patient Accounts at 800-677-5545 Monday through Friday from 8:00am-4:00pm CST.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 877-305-5145 (TTY 800-964-3013).