La Rabida Children's Hospital

6501 South Promontory Drive
Chicago, IL 60649
P: 773.363.6700

Financial Assistance Application

Patient's Name .....

Address .....

City State Zip code

Telephone (.....).....

Patient Account Number ....

Date of Service ....

Amount Due ....

Responsible Person's Name .....

Address .....

(If address information is same as patient, indicate same) City State Zip code

Relationship to Patient .....

Provide health insurance information, if covered

Insurance Company's Name .....

Address .....

City State Zip code

Telephone (.....).....

Name of Subscriber .....

Group and Policy Numbers .....

Effective Dates ...../...../..... - ...../...../.....

(Month, Date, Year Example: 01/27/2018)

Do you have coverage through the Illinois Department of Healthcare & Family Services (Public Aid) or have you applied for aid including coverage through Kid Care? Yes ☐ No ■

How many family members in the household? .....

Is any adult member of the family unable to work due to injury or illness? Yes ☐ No ☐

If yes, please explain .....

.....

Identify members of the household who are employed

Name of Employed Members	.....	.....
Occupation	.....	.....
Monthly Income	.....	.....
Number of Years Employed	.....	.....

List names and ages of dependents below

How many dependents are being supported? .....

Name of Dependent	.....	.....	.....
Date of Birth	.....	.....	.....
Name of Dependent	.....	.....	.....
Date of Birth	.....	.....	.....

(Use a separate sheet to list additional dependents.)

Is the household receiving any money as a result of child support payments, alimony, Social Security income or any other income? Yes ☐ No ☐
If "Yes" indicate source of income and monthly dollar amount: $ .....

List medical or financial problems within the household .....

.....

Do you expect to receive payment for these services from any other source including accident or liability coverage?
Yes ☐ No ☐

Proof of income must be provided. Attach most recent income tax return form and/or the most recent 4 weeks of pay stubs. If receiving Social Security benefits or any other income in addition to the above, attach copies.

Responsible Person's Signature ..... DATE ...../...../.....

Hospital Representative's Signature .....DATE ...../...../.....

(Month, Date, Year Example: 01/27/18)