Provena Health – Resurrection Health Care Home Health Financial Assistance

NOTE: This application is for Home Health charges only.

Date of Application: _____

1. PATIENT INFORMATION *: -PLEASE PRINT ALL INFORMATION-

Last Name	First Name	Middle Initial

* If the patient is a minor or full-time student, please list parent(s)/guardian(s) as applicant and co-applicant

2. APPLICANT (PATIENT/PARENT) INFORMATION:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip	Home Phone ( )

Current Employer	Street Address	Phone	Position	Years Employed

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

3. CO-APPLICANT (SPOUSE/PARENT) INFORMATION:

Relationship to Patient ☐ Spouse ☐ Parent ☐ Other

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip	Home Phone ( )

Current Employer	Street Address	Phone	Position	Years Employed

Total Number of Dependents: (other than self and co-applicant)	Dependent Name	Date of Birth	Relationship

4. INCOME INFORMATION:

List all contributing gross income. Include gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, and regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, trusts, and veteran stipends.

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
		Total Combined Monthly Income	$ Add all income above

UNEMPLOYMENT: If you do not have monthly income, please complete the Room and Board Statement (available at www.provenaresurrection.org/financialassistance) or submit a letter of support from whoever is assisting you.

5. ADDITIONAL INFORMATION/COMMENTS:

6. SIGNATURE:

By signing below I certify that all information is valid and complete. I will immediately notify Provena Health – Resurrection Health Care Home Health if my financial circumstances change.

Applicant Signature	Date	Co-applicant Signature	Date

Please submit the following information with your application:

- ☐ Federal Income Tax Return - *preferred* (or) 2 most recent paycheck stubs or other proof of income
- ☐ Driver's License / state-issued ID (or proof of IL residence)

If applicable, please submit the following:

- ☐ Social Security Award Letter
- ☐ Financial Award Letter(s) for any student loans or grants
- ☐ Food Stamp Award Letter
- ☐ Room and Board Statement / Letter of Support (if no income)
- ☐ Unemployment Compensation Benefit Award Letter

Return completed form and supporting documents to:

Provena Home Health
Patient Financial Services
9223 W. St. Francis Rd
Frankfort, IL 60423

Resurrection Home Health
Patient Financial Services
2380 E Dempster Street
Des Plaines, IL 60016

If you have any questions or need additional assistance, please contact us at 815-806-2300 (Provena Health) or 847-493-4800 (Resurrection Health Care) or visit www.provenaresurrection.org/FinancialAssistance for additional information.

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Room and Board Statement

_____
Patient Name: (Print)

The person named above has advised us that you either contribute substantially to their support or you are their sole means of support.

The type of support I / we provide is: (please complete all that apply)

_____ Room and Board, since (date) _____

_____ Allowance of $ _____

every week ____ , every 2 weeks ____, every month ____

_____ Other (please explain) _____

_____

I / We, (print) _____ have been the sole/substantial support for the person named above and, to the best of my / our knowledge, declare that this person has no other primary means of support. I/We will continue to provide room and board, but will not be responsible for medical expenses incurred.

_____	_____
Signature 1	Signature 2
_____	_____
Relationship to Patient	Relationship to Patient
_____	_____
Address, Street	City, State Zip
_____	_____
Telephone	Date