



The following documentation is needed in order to process the Charity Care application for Saint Anthony Hospital.

- **Identification.** (driver's license, passport, SS card, Etc.)
- **Proof of income.**
 - W2's, previous year income tax returns Federal and State,
 - 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) notarized.
- **Proof of dependents.** (if not listed on tax forms)
 - Birth Certificate, Social Security card or Identification.

Copies of the above documents are required, original documents will not be returned. If you have any questions please feel free to contact us at 773.484.4800 from 8:30 AM to 3:30 PM Monday thru Friday.

**PLEASE MAIL ALL THE DOCUMENTATION TO:
SAINT ANTHONY HOSPITAL
1849 PAYSHERE CIRCLE
CHICAGO, ILLINOIS 60674
ATTN: CUSTOMER SERVICE REP.**

**SAINT ANTHONY HOSPITAL
CHARITY CARE ASSISTANCE APPLICATION**

DATE: ____/____/____

RETURN BY ____/____/____

PATIENT NAME: _____

TELEPHONE: (____) ____ - ____

GUARANTOR: _____

TELEPHONE: (____) ____ - ____

ACCOUNT BILLING NUMBER (S)

DATE OF SERVICE: ____/____/____

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: _____

Phone Number: _____

Phone Number: _____

Marital Status: Single

Married

Divorced

Dependents	Name		Social Security Number
1			
2			
3			
4			
5			
6			
7			

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 _____

HOSPITAL USE:

APPROVED % _____

Date _____

DENIED/REASON _____

Date _____