

Loyola University Medical Center

Application for Financial Assistance

Patient Name: _____ **Date of Birth:** _____

Family Size: _____ **Annual Household Income** _____

Patient or Guarantor Information

Name: _____ **Relationship to Patient:** _____

Address: _____ **Telephone:** (_____) _____

_____ **Cell Phone:** (_____) _____

Employer Name: _____ **Occupation:** _____

__ Full Time __ Part Time

Primary or Legal Residence (Guarantor)

Address: _____

Monthly Payment \$ _____ **Own** _____ **Rent** _____ **Other** _____

(List Additional Information on the Back Including Bank Account Information)

You may be eligible for Loyola University Medical Center financial assistance program. To help us determine if you are qualified to receive assistance, please complete and return the enclosed application along with copies of any of the following documents that you have:

- Your three most recent paycheck stubs or other proof of income
- Your most recent federal income tax return, schedules and W2s
- Social Security award letter (income or disability)
- Checking & Savings account statement
- Driver's license or other state-issued ID
- Unemployment Compensation Benefit Award Letter
- Room & Board Statement
- Rent receipt or Lease

Please send the application & all supporting documents in the enclosed postage-paid envelope to:

**Loyola University Medical Center, Patient Financial Services, Mulcahy Building,
2160 South First Avenue, Maywood, IL 60153**

We will respond to you within 30 business days of receiving your application packet. If you have any other questions or need help completing the application, please call us at the number below.

Patient Financial Services Department 800-424-4840