Assistance Application

Patient Name: ______________________________

MRN (If applicable): ______________________________

To determine whether you or your family member may be eligible for assistance or discounted care it is mandatory to complete this application and provide supporting documentation. Providing this information will help Wheaton Eye Clinic (WEC) determine if you qualify for either option in our Assistance program. The Application will be considered only upon completion of its entirety including supporting documentation.

Patient		
Patient name	Social security # (optional)	Date of Birth
Home Address	State	Zip
Home Phone Number	Cell Phone Number	Email Address
Preferred Method of Contact	Annual Household Income	
Patient's Marital Status	# of individuals in your household (as reported on your taxes)	
Employment Status		
Employer Name	Employer Phone #	
Home Address	State	Zip
Name of health insurance plan offered by employer (including COBRA)	___ Health Insurance Not Provided	

Relationship to Patient (when applicable)			
Relationship to Patient	Social Security # (optional)	Date of Birth	
Name			
Employment Status			
Employer Name	Phone Number		
Employer Address	City	State	Zip
Name of health insurance plan offered by employer (including COBRA)	___ Health Insurance Not Provided		

Assistance Application

Patient Name: ____________________________

MRN (If applicable): ____________________________

QUESTIONNAIRE
1. Is the Patient an Illinois resident ? Yes___ No ____
2. Are you a foreign national residing in Illinois on a U.S. Visa? Yes___ No___ a. If so, what type of Visa? ____________________________________
3. If you are divorced or separated, is your former spouse/partner financially responsible for medical care per the dissolution or separation agreement? Yes _________ No ___________ N/A _________
4. Is the treatment provided related to any of the following? Accident ____ Crime _____ Workplace Injury ____ Other ____________________________
5. Have you already applied for Medicaid? (*we may require that you do so)* Yes —waiting approval___ Yes - not eligible___ No ____ a. If no, provide reason: ______________________________ 6. Have you submitted for Redetermination? Yes, what was the result? ________________ No, What is the date that you are due for redetermination? _______________________

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 bill. I understand that the information provided may be verified by Wheaton Eye Clinic and I authorize Wheaton Eye Clinic 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, or if the Application otherwise contains a material error or omission, I will be ineligible for financial assistance, and any financial assistance granted to me may be reversed and I will be responsible for the payment of all previous charges.

____ Patient Signature

____ Spouse/Partner/Parent/Guardian Signature (when applicable)

____ Date

____ Date

Supporting Documentation MUST include the following;

2 years of tax returns and paycheck stubs (Last 60 days)

Furnish two identification documents from below

- Drivers License
- Identification card

Please return completed Application and Supporting documents to:

Wheaton Eye Clinic
Attn: Patient Accounts
2015 N Main Street
Wheaton IL 60187
Ph: 630.668.8250/Fax 630.668.8916
Email: PatientAccounts@wheatoneye.com

Internal Use Only:

Determination: ______________________ **Reviewer Initials:** ______________________	**Date:** ___________