ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

Patient Information

The information in this application will be used to identify if you qualify for any methods of financial assistance. We will use the information you give us in an effort to help you obtain payment from other sources.

Be sure to give full information for everyone living in your home, and complete the three sections on the right side of this form. If you don't return complete information, your request can not be processed.

Our team members may try to find out if you qualify for other federal or state assistance programs, copay assistance or grants prior to processing your request for financial assistance from Illinois CancerCare.

All information will be kept PRIVATE.

Complete all THREE SECTIONS

1. Financial Assistance Application

Fill this attached form out completely, please remember to sign the bottom of page two.

You only need to fill out one form for everyone living in your home.

2. Proof of Income *(for everyone in your home)*

Send copies of all items listed below that apply.*

- ❑ Tax return for last year
- ❑ If you are employed: pay stub with year-to-date income OR your last 3 pay stubs
- ❑ If you are self-employed: balance sheet and income statement
- ❑ If you are unemployed: state unemployment claim AND final pay stub from last job
- ❑ Monthly pension amount letter
- ❑ Disability income amount letter
- ❑ Social security income amount letter
- ❑ Proof of income from rent
- ❑ Proof of income from child support
- ❑ Proof of income from alimony
- ❑ If you have NO income, written statement from the person who supports you

3. Proof of Assets *(for everyone in your home)*

Send copies of all items listed below that apply.*

- ❑ Bank Statements from the last 3 months
- ❑ Investment statements (401K, IRA, investment account, health savings account)

** Do NOT mail original documents. Send copies only.*

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If you have any questions after reading through these instructions, Please feel free to call Illinois CancerCare at 309-243-3500.

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Household Summary

Patient Acct#: _____

Patient / Responsible Party

Name *(First, Middle, Last)*		Social Security Number		Birth Date *(Month DD, YYYY)*
Address		City	State	ZIP Code
Phone	Household Size *(Patient, Spouse and Dependents)*		Marital Status	
Employment Status ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Unemployed ❑ Student ❑ Retired/Disabled		Employer Name		
Employment Length	Unemployed Date/Length *(Month DD, YYYY)*	Are you claimed on another tax return? ❑ Yes ❑ No (If yes, provide tax returns of those being claimed)		

Spouse / Partner

Name *(First, Middle, Last)*		Social Security Number	Birth Date *(Month DD, YYYY)*
Employment Status ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Unemployed ❑ Student ❑ Retired/Disabled		Employer Name	
Employment Length	Unemployed Date/Length *(Month DD, YYYY)*		

List All Other People Living In Household

Full Name	Relationship	Birth Date *(Month DD, YYYY)*
1.		
2.		
3.		
4.		

Reason You Need Help With Your Bill

I have applied for or will apply for federal or state medical assistance or have verified my healthcare exchange plan eligibility.

❑ Yes ❑ No Reason _____

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Financial Summary

Patient Acct#: _____

Income			
Source of Income	Amount Received	How Often Received	Name of Person Receiving
Employment Income - Patient			
Employment Income - Spouse			
Social Security			
Child Support / Alimony			
Pension / Compensation / Unemployment			
Interest / Dividend			
Other (Explain)			

Assets		
Item	Account Balance	Description
Checking Account		
Savings Account		
Stocks / Bonds / CD's		
401(K) / IRA / Health Savings Account		
Motor Vehicles (Make & Model / Year)		
Main Home (Assessed Value)		
Other Property Owned		
Total Assets:		

Expenses			
Item	Total Amount Owed	Monthly Payments	Description
Home Mortgage			
Rent (Monthly Payment)			
Utilities (Electric, Water, etc.)			
Medical Bills			
Alimony / Child Support			
Prescription Medicines			
Bank Loans (Car)			
Bank Loans (Personal, Student Loans, etc)			
Insurance (Auto, Health, etc)			
Credit Card Debt			
Other (Explain)			
Total Liabilities:			

CONSENT FOR RELEASE OF INFORMATION

I certify all information 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 services provided by ILCC. I understand that provision of any false or misleading claims, statements, documents or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Illinois CancerCare, its affiliates and representatives to investigate the information contained herein. I also agree to notify Illinois CancerCare of any changes in my financial position that would impact this determination.

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____