

Chicago Lakeshore Hospital

4840 North Marine Drive
Chicago, Illinois 60640-4220
Fax (773) 907-4607/Phone (773) 878-9700

Date _____

Dear Patient:

You will find enclosed, a copy of a financial statement for Chicago Lakeshore Hospital. This form is used to determine your ability to pay on any outstanding accounts. In order to have a portion of your accounts considered for discount care, **this form must be completed and returned within ten(10) business days to the address listed above.**

To receive full consideration, the following documents must be returned with your application:

1. Your last two wage or earning statements
2. Your completed previous year tax return
3. Your last two monthly bank statements
4. Any other document that you feel would justify your need for assistance

If there are any of the documents listed above that you cannot provide, please prepare a detailed statement fully explaining the reasons. **The completion of this application does not guarantee that any of your outstanding debt will be waived or discounted;** only that it will be reviewed for consideration. You will be responsible for any outstanding out-of-pocket expenses on your account.

Regardless of the outcome, please note that failure to satisfy your outstanding debt timely will result in your accounts being referred to a collection agency. Please mail the completed form and all related financial documents to: *Chicago Lakeshore Hospital, 4840 North Marine Drive, Chicago, IL 60640, Attn. Business Office and feel free to call with any questions or concerns you may have.*

Sincerely,
Patient Financial Services
Chicago Lakeshore Hospital