COOK COUNTY HEALTH

Room and Board / Financial Assistance Statement

Cook County Health is here to support our community and patients by providing supplementary health insurance coverage when needed. **We care for all patients, regardless of their race or immigration status**. In order to provide assistance, we need your help by filling in the necessary information below.

Date: _____

This is to inform you that I am the _____ of _____.

He/She has been receiving help from me since _____. I provide _____.

Although I provide the above, I am not, nor have I ever been financially able to help with the medical expenses. I assume no responsibility for these expenses.

_____
Patient Name

_____
Provider of Room & Board / Financial Assistance Signature

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number