

**Palos Community Hospital
Request for Financial Assistance**

Patient Name: _____ Date: _____

Guarantor Name: _____

Account Number(s): _____

Total Balance Due: \$ _____

In order to properly evaluate your need for financial assistance, please complete the following:

1. Please fully complete and sign the attached financial statement.
2. Submission of the following documents along with the completed application.
 - a. A copy of your most recent tax forms with corresponding W-2 forms.
 - b. A copy of your paycheck stubs and your spouse's paycheck stubs for the last three pay periods if applicable.
 - c. A copy of your award letter from Social Security.
 - d. Copies of your unemployment checks.
 - e. If you are a full time student, please provide proof of enrollment.
 - f. Please provide a letter/written statement explaining your need for financial assistance.
 - g. A notarized signature of person(s) assisting with living conditions or financial assistance.

Please forward the completed application and all documentation to:

Director of Patient Financial Services
Palos Community Hospital
12251 S. 80th Avenue
Palos Heights, IL 60463

If you have any questions regarding the form, please contact the Business Office at our toll free number (866) 395-4723.

Financial Application

Please fill out application completely and to the best of your knowledge.

Name (First, Middle, Last)		Date of Birth	Social Security Number
Home Address (include apt. #)		City	State Home Phone Number
Employer's Name		Position	Employer's Address
Employer's Phone ()	Employment Length Years Months	Monthly Gross Salary \$	

Spouse's Name (if applicable)

Name (First, Middle, Last)		Date of Birth	Social Security Number
Employer's Name		Position	Employer's Address
Employer's Phone ()	Employment Length Years Months	Monthly Gross Salary \$	

If there is no income, send notarized proof of living conditions and any financial help received from any source other than those mentioned in this document. A notarized signature of person(s) assisting with living conditions or financial assistance other than those mentioned in this document is required.

Source of Other Income (Please indicate Monthly Amount)

Social Security	\$	Alimony/Child Support	\$
Pensions (list each)	\$	Interest/Dividend (list)	\$
1.		1.	
2.		2.	
3.		3.	
Unemployment	\$	Rental Income (house and land)	\$
Public Assistance	\$	Other (please explain)	\$

Additional Information Regarding Finance

Property Other Than Home Dwelling (Exclude business and rental property) Describe type of property including farm land, undeveloped land, etc.	Automobiles (List model, make and year of all autos.)	
Value of Property: \$	Checking Account Number and Average Balance: \$	
Amount Owed On Property: \$	Savings Account Number and Average Balance: \$	
Other Property: Value of Property: \$ Amount Owed on Property: \$	Name of Bank(s) 1. 2.	
Location of Property(s) 1. 2.	Address of Bank(s) 1. 2.	
If you are not employed, are you <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student	Non Retirement Accounts:	Stocks/Bonds: \$
If you are a full-time student list the name and and phone number of the school.	Certificates of Deposit: \$	

List dependent children and attach proof of dependency if child is over age of 18.

Name	Relationship	Birthdate	Months in Applicant's Home

Monthly Obligations:

Rent/House Payment	\$	Recreation/Entertainment	\$
Light & Heat	\$	Car Insurance (monthly)	\$
Water & Sewer	\$	Doctor/Dentist/Medical	\$
Garbage Removal	\$	Books/Magazine/Newspaper	\$
Telephone	\$	Food & Household Supplies	\$
Clothing	\$	Medical Insurance	\$
Car Payment	\$	Life Insurance	\$
Cable TV	\$	Rent/House Insurance	\$
School Expense	\$	Miscellaneous (explain)	\$
Charities	\$	TOTAL MONTHLY OBLIGATIONS	\$

Creditors (i.e. credit cards, auto, medical, etc.) Attach copies of medical.

Name & Address of Creditor	What was purchased?	Amount Financed	Unpaid Balance	Monthly Payments

I/We hereby certify that I/we are of legal age and that the forgoing statements are true and complete and are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain your property, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made therein, and to determine my/our credit worthiness, including, but not limited to procuring consumer reports from consumer reporting agencies, and credit information from bank and other financial institutions and expenders of credit, references, present and former employers, merchants, landlords and creditors.

Signature of Applicant _____ Date _____

Signature of Spouse (if applicable) _____ Date _____



Palos Community Hospital

12251 S. 80th Avenue • Palos Heights, Illinois 60463 • (708) 923-4000

For your convenience, please use this page to write your statement explaining your need for financial assistance. You may also use this page for your notarized statement of proof of living conditions.

Signature of Patient/Guarantor

Date

Signed and sworn to before me this _____ day of _____ 20____.

Notary Public