IROQUOIS MEMORIAL HOSPITAL
PATIENT FINANCIAL ASSISTANCE PROGRAM

Date of Application: _____ **Date of Discharge:** _____

Applicant's Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Telephone_____ Date of Birth_____

Guarantor's Name_____ Date_____

Social Security Number_____

Patient's Employer Name_____

Address_____

City_____ State_____ Zip_____

Telephone_____

Spouse's Employer Name_____

Address_____

City_____ State_____ Zip_____

Telephone_____

Family Members (List all members living in household and their date(s) of birth):

1. _____DOB_____ 5. _____DOB_____
2. _____DOB_____ 6. _____DOB_____
3. _____DOB_____ 7. _____DOB_____
4. _____DOB_____ 8. _____DOB_____

Total Family Size: _____

Health Insurance Company_____ **Policy Number:**_____

Estimated Gross Family Income (from all sources):

Previous Three Months: _____

Previous Twelve Months: _____

I affirm by my signature below that the information contained on and attached to this application is true to the best of my knowledge. I understand that the information which I submit to Iroquois Memorial Hospital is subject to verification. I agree to provide additional information as requested in order to determine eligibility.

Applicant's Signature_____

Relationship (if other than patient)_____ **Date**_____

The following information is required to determine eligibility:

Proof of income:

A. Federal income tax return (most recent calendar year)
B. Payroll check stubs;
C. Bank statements
D. Employer statement, if applicable
E. Social Security benefits, pensions, if applicable

OFFICE USE ONLY

Discount % Approved_____ Expiration Date_____

Approval Signature_____ Date Approved_____

PLEASE NOTE, YOU MUST CONTACT A FINANCIAL COUNSELOR IF YOU DESIRE ADDITIONAL SERVICES TO BE INCLUDED IN THIS ORIGINAL APPLICATION.

This application for financial assistance has been denied for the following reason(s):

_____ Your household income exceeds the allowable amount

_____ No proof of income

_____ Other_____

Mail completed application to:
Iroquois Memorial Hospital
Patient Financial Services
200 Fairman
Watseka, Illinois 60970
(815)432-7741 or 1(800)242-2731

Eff. 10/01/13