



5601 S. County Line Road
Hinsdale, IL 60521
(630) 286-4516

Request for Financial Assistance

ACCOUNT #: _____

NAME: _____
First Middle Last

ADDRESS: _____
Street Address

City State Zip Code

TELEPHONE: (_____) _____

DATE OF BIRTH: ____/____/____ **SOCIAL SECURITY #:** _____
Month Date Year

Please Check One:

1. **Family Size:** Number of adults in your immediate family: _____

<u>Name</u>	<u>Age</u>	<u>Sex</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Potential Third Party Payer Source:

Private Insurance Medicaid Medicare Self Pay None
Other _____

3. Family Principal Income Source:

Professional/Technical Employment	<input type="checkbox"/>	Labor/Production Employment	<input type="checkbox"/>
Agricultural Employment	<input type="checkbox"/>	Services/Sales Employment	<input type="checkbox"/>
Unemployment Compensation	<input type="checkbox"/>	Retirement Income	<input type="checkbox"/>
Disability Income	<input type="checkbox"/>	General Relief	<input type="checkbox"/>
None	<input type="checkbox"/>	Other Income Source	<input type="checkbox"/>

4. List Income for Family:

<u>Source:</u>	Monthly/Annual
Wages (Self)	_____
Wages (Spouse)	_____
Wages (Other Family Members)	_____
Farm or Self-Employment	_____
Public Assistance	_____
Unemployment Compensation	_____
Worker's Compensation	_____
Strike Benefits	_____
Alimony	_____
Child Support	_____
Military Family Allotments	_____
Pensions	_____
Income from Dividends, Interest, Rent	_____
TOTAL	\$ _____

5. Type of Program/Service:

Vent Program Wound Care Program Complex Medical Program
Outpatient Pulmonary Rehab Program

6. Units of Service:

Date of Service _____
Number of Inpatient Days _____
Billed Amount \$ _____
Repayment Collected \$ _____
Other Write-Offs \$ _____
Patient Liability \$ _____

7. Monthly Expenses:

Auto Insurance	_____
Auto Loans	_____
Child Support	_____
Credit Union	_____
Finance Companies	_____
Food	_____
Hospital	_____
Life Insurance Policies	_____
Medical Bills	_____
Medical Insurance	_____
Medication	_____
Mortgage/Rent	_____
Physicians	_____
Telephone	_____
Utilities	_____
Total Expense	\$ _____
Net Worth	\$ _____

8: Value of Assets:

Home Property	\$ _____
Automobile (s)	_____
401(k)/IRA	_____
Pension	_____
Credit Union	_____
Checking	_____
Checking	_____
Savings	_____
Savings	_____
Stocks/Bonds	_____
Jewelry	_____
Other	_____
Other	_____
Net Worth (Asset-Liabilities)	\$ _____

Value of Liabilities:

Home Property	\$ _____
Automobile (s)	_____
Credit Card	_____
Credit Card	_____
Credit Card	_____
Other	_____
Other	_____

9. Bank References:

Name/Branch: _____ Account # _____

Name/Branch: _____ Account # _____

Total net value of all items in this section: _____

10. Liability Computation:

+ Total Monthly Gross Income	(A) _____	Adjusted Net Monthly
- Total Monthly Deductions	(B) _____	
Income	(A-B) _____	

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of service within ten (10) days if there are any changes in my

(or the persons on whose behalf I am acting) income, property, expenses or in the persons in the household or any change of address.

- I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank , credit verification and property searches.
- I understand the hospital is required by law to keep my information I provide confidential.
- I further agree, that in consideration or receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.

Signature

Today's Date

For Hospital Use Only:

Accepted Denied

Comments: _____

Signature

Today's Date