

HAMILTON MEMORIAL HOSPITAL  
PO BOX 429  
MCLEANSBORO, IL 62859  
618-643-2361

#### FINANCIAL ASSISTANCE APPLICATION PROCESS

You may request a Financial Assistance Application from the Business Office by calling extension 275.

In order to have your application processed you must submit the following with your completed application:

1. Your denial letter from Illinois Public Aid.
2. 60 days proof of income. If not available, then most recent years tax return.
3. Proof of monthly payments to creditors.

You must complete and return your application within 30 days of discharge.

Once application and all information is received by the Hamilton Memorial Collections Coordinator, it is submitted for review to the Business Office Director and CFO. You will be notified within 30 days after your completed information is received if you qualify for assistance.

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Financial Assistance Application  
(All Information will be kept confidential)

In order to substantiate your need for payments lower than the requested payment amount per month, or to determine if you meet Charity Care Guidelines, please complete & sign the Financial Assistance Application & return with 30 days of discharge date. Include proof of monthly payments to creditors & balances due & verification of all household income for the last 60 days. Acceptable income verifications are: Paycheck stubs or statement of income signed by your employer, Bank statement record of deposit with Social Security or VA benefit notifications.

Income

Your monthly Income \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Spouse monthly Income \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Other Household Income \_\_\_\_\_ Source: \_\_\_\_\_

Total Income: \_\_\_\_\_

If you did not list any income above, how are you being supported at this time? \_\_\_\_\_

Dependents in Household:

Name:	Age	Name:	Age
_____	_____	_____	_____
_____	_____	_____	_____

Resources:

Checking Account Balance \$ \_\_\_\_\_

Savings Account Balance \$ \_\_\_\_\_

Stocks or Bond \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

Do you own your home? \_\_\_\_\_ If yes, list value: \$ \_\_\_\_\_  
If no, what is your monthly rent? \$ \_\_\_\_\_

List make & model of any vehicle's, campers, ATV's, boats, etc. that you own:

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Creditors (Include Credit Cards, bank loans, cable tv, telephone, cell phones, utilities, etc.)

<u>Creditors Name</u>	<u>Monthly Payments</u>	<u>Current Balances</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments you would like to make regarding your financial situation.

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I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE & COMPLETE AND ARE MADE FOR THE SOLE PURPOSE OF DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE. I AUTHORIZE HAMILTON MEMORIAL HOSPITAL TO MAKE INQUIRIES THAT ARE DEEMED NECESSARY TO VERIFY THE ACCURACY OF THE STATEMENTS INCLUDING BUT NOT LIMITED TO, CONSUMER RECORDS FROM CONSUMER REPORTING AGENCIES & CREDIT INFORMATION FROM LISTED BANK & OTHER FINANCIAL INSTITUTIONS, PRESENT AND FORMER EMPLOYERS, LANDLORDS & CREDITORS. I ALSO AUTHORIZE ANY PERSON FROM THE LISTED CREDITORS TO FURNISH HAMILTON MEMORIAL HOSPITAL ANY INFORMATION THAT IT MAY HAVE OR OBTAIN IN RESPONSE TO CREDIT INQUIRIES.

\_\_\_\_\_  
Patient or Guarantor Signature

\_\_\_\_\_  
Date