FAIRFIELD MEMORIAL HOSPITAL
303 NW 11TH STREET
FAIRFIELD, ILLINOIS 62837
618-842-2611

HORIZON HEALTHCARE
213 NW 10TH STREET, STE. A
FAIRFIELD, ILLINOIS 62837
618-842-4617

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME: _____ PHONE #: _____

PATIENT ADDRESS: _____

EMPLOYER: _____

INCOME:

$ _____ Total gross income for the past twelve months for ALL members of the household must be listed**. Proof of income must be returned with this application - Complete Income Tax Form 1040 with schedules, W-2 Form and a current paycheck stub with year to date income.**

Wages	$_____	Child Support	$_____
Farm or Self-Employment	$_____	Pension/ADC/Welfare	$_____
Public Assistance	$_____	Rental Income	$_____
Social Security	$_____	Food Stamps	$_____
Unemployment Compensation	$_____	Insurance Disability	$_____
Worker's Compensation	$_____	Other	$_____
Alimony	$_____	Other	$_____
If unemployed, date last worked _____		☐ No taxes were filed	

ASSETS:

Auto/Autos (year & make) _____	$ _____	
Land/Real Estate (other than residence) _____	_____	
Stocks/Bonds/Royalties _____	_____	
Savings/CDs/Money Market _____	_____	
Recreation Vehicle/Boat (year & make) _____	_____	

HOUSEHOLD SIZE:

NAME	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOUSING ARRANGEMENTS:

_____ Buying _____ Renting _____ Own-Value $ _____

_____ Living with _____

I understand that the information which I submit is subject to verification by Fairfield Memorial Hospital. Under penalty of perjury I declare that the information provided is true, correct, and complete.

Applicant's Signature: _____ Date of Request _____

Applicant's Signature: _____ Date of Request _____

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☐ Application Approved ☐ Application Denied

(12-12)

_____
(Hospital Representative Signature) Date