FAIRFIELD MEMORIAL HOSPITAL
FAIRFIELD, ILLINOIS 62837
618-847-8244

# APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME: ____________________________________________

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 - Income Tax Form 1040 or W-2 Form and a current paycheck stub with year to date income.

| | | | |
|---|---|---|---|
| Wages | $___________________ | Child Support | $___________________ |
| Farm or Self-Employment | $___________________ | Military Family Allotment | $___________________ |
| Public Assistance | $___________________ | Pension/ADC/Welfare | $___________________ |
| Social Security | $___________________ | Rental Income | $___________________ |
| Unemployment Compensation | $___________________ | Food Stamps | $___________________ |
| Worker's Compensation | $___________________ | Insurance Disability | $___________________ |
| Strike Benefits | $___________________ | Other | $___________________ |
| Alimony | $___________________ | Other | $___________________ |

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 | D.O.B. | 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 _______________

____________ Application Approved
____________ Application Denied

(3-08)

_______________________________________________________
(Hospital Representative Signature) Date