Rochelle Community Hospital

ROCHELLE COMMUNITY HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Patient or Patient Representative is required to complete the following application. The patient or an authorized agent for the patient must sign this form. Attach necessary support documentation as indicated on cover letter.

Patient Name: _____ Home/Cell Telephone Number: _____

Patient Address: _____
Street Address City State Zip

Patient Social Security Number: _____ Patient Date of Birth: _____

Patient's Occupation: _____ Length of Employment: _____

Employer Name and Address: _____

Patient Income: _____ ____ Weekly ___ Monthly ___ Annual

Spouse's Occupation: _____ Length of Employment: _____

Spouse's Employer Name and Address: _____

Spouse's Income: _____ ____ Weekly ___ Monthly ___ Annual

Other Income for Patient and/or Spouse:

Social Security Income: _____ Pension: _____

Unemployment: _____ Interest Income: _____

Alimony: _____ Self-Employment: _____

Disability or Worker's Comp: _____ Other: _____
(Specify Source)

Asset Information:

Bank Account (s), list bank name and balance in account:

_____

_____

List all family members who either live in your home or you are allowed to claim on your Federal income tax return:

Family Member Name	**Date of Birth**	**Relationship to Patient**
1.		Patient
2.		Spouse
3.		
4.		
5.		
6.		
7.		
8.		
9		
10.		

I hereby certify that the foregoing statements are true and complete and are made for the sole purpose of determining eligibility for financial assistance. I agree to provide the necessary verification of my income. I authorize Rochelle Community Hospital to make inquiries that are deemed necessary to verify the accuracy of the statements including but not limited to, consumer reports from consumer reporting agencies and credit information from listed bank and other financial institutions, present and former employers, landlords and creditors. I also authorize any person or consumer reporting agency to furnish Rochelle Community Hospital with any information that it may have or obtain in response to credit inquiries.

_____ _____

Patient or Applicant Signature Date

05/2016