Date: _______________

Dear: ____________________,

RE Account Number(s): ____

Balance due at Rochelle Community Hospital: ______________________

Rochelle Community Hospital endeavors to provide quality health care to meet the needs of all people in the community it serves. Upon request, the hospital will process applications for uncompensated care from individuals who feel they are unable to pay for services rendered.

Please be advised at the present time, we are unable to determine eligibility for assistance. We will evaluate and adjust your bill accordingly after receiving additional information. Please provide copes of the following items:

_____Financial Assistance Application Form

_____W-2 and/or 1099 statements

_____Pay check stubs or unemployment check stubs, past three months

_____Statements from Social Security, past 3 months

_____Prior year Income Tax Returns

_____Checking and Savings Account Bank Statements

Failure to provide this information within the next two weeks could disqualify you from assistance. Please note accounts that have been placed with an outside agency will not be eligible for charity assistance. Payment arrangements for those accounts will need to be made directly with those agencies.

Your cooperation with Rochelle Community Hospital is extremely important in determining your eligibility for assistance. Upon receipt of the above documentation, you will receive a written notice from the hospital within 30 days indicating your eligibility and any payment obligation due from you.

Sincerely,

Doris Dickey, CPAM
Business Services Manager
Rochelle Community Hospital