



**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 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: \_\_\_\_\_

Own Home:  Yes  No Approx. balance due on mortgage: \_\_\_\_\_

Name and Address of Mortgage Holder or Landlord: \_\_\_\_\_

Rent or Mortgage Payment per Month: \_\_\_\_\_ Approx. purchase price of home: \_\_\_\_\_

Own Car:  Yes  No Year/Make of Car: \_\_\_\_\_ Approx. Value: \_\_\_\_\_

Balance due on Car Loan: \_\_\_\_\_

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List other outstanding debt and approximate balance and monthly payment amount:

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

<u>Family Member Name</u>	<u>Date of Birth</u>	<u>Relationship to Patient</u>
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 records 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 any information that it may have or obtain in response to credit inquiries.

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

\_\_\_\_\_  
Date