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: ______________________________

List below 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 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

OPTIONAL

We are required to ask for the following demographic information.
Your response or lack thereof has no influence on financial assistance determination.

Race: ____________________
Ethnicity: ____________________
Sex: ____________________
Preferred Language: ____________________

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General – (877) 305-5145.
https://www.illinoisattorneygeneral.gov/consumers/healthcare.html

10/2021