



## FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

In order to process your Financial Application, we need the following information returned to the hospital via mail or dropped off at the Information Desk in the front lobby at:

**Sherman Hospital  
Patient Financial Services  
1425 N. Randall Road  
Elgin, Illinois 60123**

1. COMPLETE ENTIRE application and SIGN where indicated. RETURN ALL DOCUMENTS together with application. Incomplete applications will not be processed.
2. Copy of a photo ID
3. Copy of either your Social Security Benefit Letter or Social Security check
4. Copy of most recent pay stubs for you, and your spouse (last four weeks). If the patient is a full-time student, then a school issued schedule of classes should be included.
5. Copy of unemployment or disability check (if receiving benefits)
6. Copy of BOTH last year's Federal Tax Return and W-2 forms
7. If there are other people living in your home, please list their relationship to you and what their monthly income is. \*\*If they are unable to help you with medical bills, please have them write a short letter as to why.
8. Itemize your monthly bills on the backside of the Financial Application. Include your monthly mortgage/rent.
9. If you are unemployed but not disabled, please indicate reason you are not currently working.

The completed application & all documentation must be received by the hospital no later than 30 days from initial date of service. (Note Financial Assistance will not be determined in advance of services.)

**The application will be denied if all necessary documentation is not submitted.**

**SHERMAN HOSPITAL  
FINANCIAL ASSISTANCE APPLICATION**

Patient Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Account Number \_\_\_\_\_ Date of Service \_\_\_\_\_

**HOUSEHOLD INFORMATION**

APPLICANT	SPOUSE
Name _____ Age _____	Name _____ Age _____
Street Address _____	Street Address _____
City _____ State _____ ZipCode _____	City _____ State _____ ZipCode _____
Soc. Sec. # _____ Home Phone _____	Soc. Sec. # _____ Home Phone _____
No. Years at address? _____ Own _____ Rent _____	No. Years at address? _____ Own _____ Rent _____
Married _____ Single _____ Separated _____	Married _____ Single _____ Separated _____
Dependents, No. _____ Ages _____	Dependents, No. _____ Ages _____
Name of Employer _____	Name of Employer _____
Yr.s this line of work _____ Yr.s this job _____	Yr.s this line of work _____ Yr.s this job _____
Position/Title _____	Position/Title _____
Business Phone _____	Business Phone _____

**GROSS MONTHLY INCOME**

APPLICANT	SPOUSE
Employment Income (per hour) _____	Employment Income (per hour) _____
Social Security Income _____	Social Security Income _____
Net Rental Income _____	Net Rental Income _____
Unemployment Income _____	Unemployment Income _____
Child Support/Alimony _____	Child Support/Alimony _____
Public Assistance _____	Public Assistance _____
Other _____	Other _____
Total _____	Total _____

List the name of other persons living in your home that have income \_\_\_\_\_  
Please list the source and amount of the additional income.

All information and income documentation provided is true, accurate and complete as shown. If it is determined at any time the information I provided is found to be false and/or inaccurate, all Financial Assistance awarded will be reversed, and I will be responsible for full and immediate payment of any and all outstanding balances.

Signature of Applicant _____	Signature of Spouse _____
Date _____	Date _____
Witness _____	

**OFFICE USE ONLY**

Total Hospital Balances _____	Gross Monthly Income _____
Total Bad Debt Balances _____	Total Family Income _____
Total Bills Considered _____	Credit Bureau Date (attach Copy) _____
_____	_____
Patient Representative	Lead Patient Representative
	Collection Manager