

In order to process your financial application, we need the following information sent to us via mail at Sherman Hospital 1425 N. Randall Rd. Elgin IL 60123 Mail code GP0196 or please drop off at the hospital information desk

_____ Complete **entire** application

_____ Copy of your Social Security Benefit Letter and/or Social Security check

_____ Spouse monthly income information (if applicable)

_____ Copy of most recent check stub (s) (last four weeks)

_____ Copy of unemployment check / disability check (if applicable)

_____ Copy of last year's tax forms/W2's

_____ If there are other people living in your home, please indicate their relationship to you and what their monthly income is.

*** If they are unable to help you with your medical bills, please have them write a short letter as to why.*

_____ Indicate on the back side of the financial application what your total monthly bills are (itemized). Include your monthly rent/mortgage.

_____ If you are unemployed but not disabled, please indicate reason you are not currently working.

_____ Other: **THIS APPLICATION CANNOT BE PROCESSED WITHOUT THE**

NECESSARY PAPERWORK ATTACHED

If you have any questions please contact our office

Sherman Hospital Business Office
Phone: 224.783.8715

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