MENDOTA COMMUNITY HOSPITAL
1315 Memorial Drive
Mendota, IL 61342
815-539-1623 or 815-539-1620

FINANCIAL ASSISTANCE APPLICATION

(ALL INFORMATION WILL BE KEPT CONFIDENTIAL)

In order to substantiate your need for payments lower than the requested payment amount per month, or to determine if you meet Charity Care Guidelines, please complete and sign the Financial Assistance Application and return within sixty (60) days of discharge date. Include proof of monthly payments to creditors and balances due and verification of all household income. Acceptable income verifications are: paycheck stubs or statement of income signed by your employer, Social Security, VA or benefit records. You must submit the last six (6) months of income.

Name:_____ Telephone No._____

Address:_____
Street or P.O. Box (Mailing Address) City State Zip Code

Self-Occupation:_____

Employer:_____
Name Address

Spouse-Occupation:_____

Employer:_____
Name Address

Dependents in Household:

Name	**Age**	**Name**	**Age**

Mendota Community Hospital

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Mendota, IL 61342
(815) 539-7461

(PFS)
104-900-005
10/08

FINANCIAL ASSISTANCE APPLICATION

Income: List income from all sources, before deductions, for all family members.

	Total For Last 6 Months	Total for Last 12 Months
Employment		
Self-Employment or Farm		
Public Assistance		
Social Security		
Unemployment Compensation		
Alimony		
Child Support		
Other Pensions or Compensations		
Disability or Workmen's Compensation		
Interest Received		

If you did not receive any income above, how are you being supported at this time?

_____

_____

_____

Resources:	**Amount**
Cash on Hand	
Checking Account	
Savings Account	
Stocks or Bonds	
Time Certificates/IRA's	
Trust Fund	
Other	

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Please list the make and market value of all vehicles, motorcycles, snowmobiles, boats, campers, four-wheelers, etc.

Model-Age	Value

Creditors / Monthly Expense / Other Debts:
(Include Credit Cards, Bank Loans, Cable TV, Telephone, Cell Phones, Etc.)

Creditor's Name	Monthly Payments	Current Balance

Are there any additional comments you wish to make concerning your financial situation?

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 authorize Mendota Community Hospital to make inquiries that are deemed necessary to verify 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 from the listed creditors to furnish Mendota Community Hospital any information that it may have or obtain in response to credit inquiries.

Patient or Guarantor Signature

Date