



Financial Assistance Application

Mail completed form to:
Business Office Director
Perry Memorial Hospital
530 Park Avenue East
Princeton, IL 61356

To be completed by the person responsible for the bill. Perry Memorial Hospital account #s _____

	Patient	Spouse/Partner
Name		
Address - Street, City, State & Zip Code		
Home Phone		
Date of Birth		
Employer		
Employer's Phone		
Hire Date		
Salary/Hourly Wage		
# Hours Worked/Week		
Gross Annual Wages		

Other Monthly Income

SSS/SSI: \$ _____ Unemployment: \$ _____ Disability: \$ _____ Pension: \$ _____
Alimony/Child Support: \$ _____ Investment Income and Other Income: \$ _____

If there is no income, how do you pay for your living expenses? _____

Total Number of Dependents? _____

Full Name _____	Date of Birth _____
Full Name _____	Date of Birth _____
Full Name _____	Date of Birth _____
Full Name _____	Date of Birth _____

Marital Status: Single Married Widowed Separated Divorced

ASSETS

Checking/Accounts: _____ Account Balance & Date: \$ _____
(List Name and Address of Institution)

Checking/Accounts: _____ Account Balance & Date: \$ _____

Savings/Money Market/CD Accounts: _____ Account Balance & Date: \$ _____
(List Name and Address of Institution)

Savings/Money Market/CD Accounts: _____ Account Balance & Date: \$ _____

Do you own your home? Yes No Amount owed \$ _____

Do you rent your home? Yes No If yes, monthly payment \$ _____

Do you own other property? Yes No If yes, describe _____ Amount owed \$ _____

List other assets owned including vehicles (cars, trucks, boats, trailers, etc)

_____	Amount owed \$ _____
_____	Amount owed \$ _____
_____	Amount owed \$ _____

List other outstanding medical expenses Provider: _____ Amount \$ _____

Provider: _____ Amount \$ _____

I certify that everything stated in this Application and on any attachment is correct. You may keep this Application whether or not it is approved. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my Application with any changed financial circumstances.

Signature _____ Date _____