



Perry Memorial Hospital

530 Park Avenue East ~ Princeton, Illinois 61356
815-875-2811

Thank you for choosing Perry Memorial Hospital for your healthcare needs. We realize people sometimes have trouble meeting healthcare expenses. You can complete this application for our Financial Assistance Program. Please mail it back with the items listed below.

Patient Name: _____ Account # _____

_____ Income for everyone living with you. Please send copies of:
 ___ Current tax return OR Last three (3) pay stubs
 ___ Documentation of pension, Social Security or SSI income, unemployment, or disability benefits
 ___ Any other forms of income that your household receives.

_____ Denial from Illinois Department of Public Aid

_____ If you have no income, please enclose a letter describing how you are meeting your day-to-day expenses.

_____ Copy of checking and savings accounts for last three (3) months.

_____ Other _____

Please return to _____, Patient Account Representative no later than _____.

If you have any questions or need assistance in completing the enclosed forms, please contact me at _____.



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: \$ _____

Do you receive Food Stamps? Yes No \$ _____

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)

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

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 _____