LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

Financial Assistance Application

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Responsible Person (If Different): _____ Date of Birth: _____

Address: _____

Number of Household Members: _____

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INCOME

Employer: _____ Address: _____

Spouse Employer: _____ Address: _____

Monthly Income:	Wages (Yours)	$_____
	Wages (Spouse)	$_____
	Unemployment	$_____
	Disability	$_____
	Food Stamps	$_____
	General Assistance	$_____
	Other	$_____

Total Monthly Income: $_____

Assets – This information will not be utilized to determine NHSC Sliding Fee eligibility

Debts and Obligations Monthly:

Mortgage/Rent	_____
Utilities: Gas, Electric, water, sewer	_____
Transportation (Car pmt., gas)	_____
Life/Medical Insurance	_____
Credit Cards	_____
Other Debts	_____
Other Medical Bills	_____
Food	_____
Other: (Please Specify)	_____
Total Debts and Obligations	$_____

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CERTIFICATION STATEMENT:

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital/clinic bill. I understand that the information provided may be verified by the hospital/clinic, and I authorize the hospital/clinic to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance provided to me may be reversed, and I will be responsible for the payment of the hospital/clinic bill.

Applicant Signature _____ Relationship _____Date: _____

Co-Applicant Signature_____ Date: _____

Nondiscrimination statement:
Lawrence County Memorial Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-943-1000. UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-943-1000

For office Use Only :

Accounts: _____

Financial Counselor Approval: _____ Amount Approved: _____

Discounted Amount: _____

PFS Director Approval_____

CFO Approval _____

Revised Date: 11.01.22