LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER
2200 State Street
Lawrenceville, IL 62439

STATEMENT OF FINANCIAL OBLIGATIONS

Before completing and signing this statement, please review all your debts carefully. Be sure that you are disclosing all debts of any kind and that the facts stated in this statement are complete and correct.

Responsible Person: _____ Age: _____

Address: _____

Spouse: _____ Age: _____

Patient Name: _____ Age: _____

Address: _____ Phone: _____

Number of Family Members: _____ Ages: _____

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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:		$_____

Note
Copies of supporting documents preferred to support income include:
Last year tax return
Last bank statement
Last 2 pay stubs
Credit Report Authorization/signed and dated
*If no reportable income, please submit a letter of reference from a person of the community who is aware of your financial status, such as; a clergy, business person, or a physician.

DEBTS AND OBLIGATIONS

Home Own ( ) Rent ( )

	Creditor	**Payment**	**Balance**
Mortgage/Rent	_____	_____	_____
Utilities	_____	_____	_____
Vehicle Loan	_____	_____	_____
Life/Medical Insurance	_____	_____	_____
Credit Cards	_____	_____	_____
	_____	_____	_____
Other Debts	_____	_____	_____
	_____	_____	_____
Other Medical Bills			
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Food	_____	_____	_____
Other: (Please Specify)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Total Debts and Obligations		$_____	$_____

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Applicant Signature _____Co-Applicant Signature_____
Date_____

Lawrence County Memorial Hospital
Credit Report Authorization

I authorize Lawrence County Memorial Hospital to generate a credit report from a national credit repository for the purpose of identifying eligibility for Financial Assistance for services provided.

_____ _____

Name SSN

Date of Birth_____ Current Address_____

_____

_____

Phone #:_____

_____ _____

Name SSN

Date of Birth_____ Current Address_____

_____

_____

Phone #:_____

Applicant Signature_____

Co-Applicant Signature_____

Date_____