LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

FINANCIAL ASSISTANCE APPLICATION

Patient Name	Date of Birth	Responsible Party (if different)	
Address	City	Address (if different)	City
Home Phone	Cell Phone	Victim of recent accident of crime (Yes or No)	
Email Address		# in Household (Self, Spouse, Children)	

Name and DOB of all Children in the household

MONTHLY INCOME (with supporting documentation)		**MONTHLY EXPENSES**	
Wages (Yours)	$_____	Housing	$_____
Wages (Spouse)	$_____	Utilities	$_____
Unemployment	$_____	Medical/Prescriptions	$_____
Disability	$_____	Food	$_____
Food Stamps	$_____	Transportation	$_____
General Assistance	$_____	Childcare	$_____
Other	$_____	Loans and Credit Cards	$_____
Total Monthly Income	$_____	**Total Monthly Expenses**	$_____

Supporting documents include copies of: W-2 statement, current pay stubs, bank statements, last year's income tax return.

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 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.

Signature	Relationship	Date

Nondiscrimination statement:
Lawrence County Memorial Hospital complies with applicable Federal civil right 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 1-618-943-7245.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-943-7245.