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.

Even a household of 4 people with income of $57,625 could qualify for some assistance. We can provide other examples by phone.

Patient Name: _____ Account # _____

Income for you and 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.

Do you get Medicaid or Food Stamps(LINK)? Enclose proof.

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 _____.

Perry Memorial Hospital

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		
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_____