

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: _____

.....

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

.....

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
Date of Birth_____

SSN
Current Address_____

Phone #:_____

Name
Date of Birth_____

SSN
Current Address_____

Phone #:_____

Applicant Signature_____

Co-Applicant Signature_____

Date_____