



FINANCIAL ASSISTANCE APPLICATION

Date:

Dear Patient,

JCH HealthCare provides a reasonable amount of care without or below charges to persons who cannot afford to pay for the services.

If you do not believe that you are able to pay for the care and treatment you need, please complete the **JCH HealthCare Financial Assistance Application** and submit proof of income within 2 weeks from the date of service or this letter.

When applying for financial assistance, we must have the following information from everyone in the household even if they are not responsible for your bills. The following documents **MUST** be included with your Financial Assistance Application:

- Federal tax return with W-2's**
- 3 months of income statements**
(pay stubs, rental income, Social Security, unemployment, worker's compensation, alimony, child support or other forms of income)
- 3 months of checking & savings account statements**
If you do not have checking or savings, please send copies of all bills.

After a request is received, a written notification of approval or denial will be sent to you. If you have any further questions, please contact the JCH Financial Counselor at 618.498.8326.

Thank you,

JCH Financial Counselor
Jersey Community Hospital
400 Maple Summit Road
Jerseyville, IL 62052
618.498.8326
(Office located at the Main Entrance of Jersey Community Hospital)

Please complete the JCH HealthCare Financial Assistance Application and ALL supporting documentation.

Instructions: Complete the application in full, **sign** the authorization to verify information.

Applicant Information

Last Name			First	M.I.	Date of Birth	Social Security Number		# of Dependents
Street		Apt #	City		State	Zip	Home Phone	
Employer			Position			Cell Phone		
Employer Address			City		State	Zip	Work Phone	

Co-Applicant – Must complete if you rely on the income of another person(s)

Last Name			First	M.I.	Date of Birth	Social Security Number		Relationship
Employer		Position			Cell Phone			
Employer Address			City		State	Zip	Work Phone	

Dependent Information

Name			Age	Live at above address	Name		Age	Live at above address
				Yes No				Yes No
Name			Age	Live at above address	Name		Age	Live at above address
				Yes No				Yes No

Description of Income

Description of Income	Paid To	Gross Amount (before taxes/deductions)
__ Weekly __ Bi-Weekly __ Monthly		
__ Weekly __ Bi-Weekly __ Monthly		
__ Weekly __ Bi-Weekly __ Monthly		
__ Weekly __ Bi-Weekly __ Monthly		

Assets/Banking Information

Checking Account		Bank Name		Savings Account		Bank Name	
Year		Make Model		Year Purchased		Tax Assessed Value	
Year		Make Model		Year Purchased		Loan Balance	
Year		Make Model		RV/Boat			

Monthly Expenses

Rent/Mortgage		Utilities		Water/Sewer		Telephone	
Groceries		Auto Payment(s)		Auto Insurance		Health Insurance	
Property taxes not included in Mortgage		Other (Describe)		Other (Describe)		Other (Describe)	
Other (Describe)		Other (Describe)		Other (Describe)		Other (Describe)	

I certify that all information stated in this Application and on any attachments 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 or requests for additional information/documentation. Charity assistance may be extended to subsequent treatment subject to full disclosure of any additional financial information requested. I understand that I cannot apply for if I have a pending liability claim, worker's compensation claim, or insurance claim. If it is determined at anytime the information I provided is found to be false and/or inaccurate, all charity care will be reversed and I will accept responsibility for full and immediate payment of any and all outstanding balances. I also agree to accept payment responsibility according to the terms and conditions of JCH for any amount due after any partial assistance may be awarded.

Signature:

Date: