Dear Patient:

The financial assistance program provides patients that do not have any other means of getting help to pay off their account(s). Depending on the income verification, the patient or guarantor may qualify for 10% to 100% write off. Please take the time to fill out the necessary paperwork so we may evaluate your application for assistance.

In order to start the evaluation process we will need the following documents from you:

- Completed application (please make sure you sign the application)
- Copy of last years tax return(1040 form) including all schedules and attachments, if you are a Medicare patient and do not file taxes, then we will require a copy of the "monthly summary of benefits"
- Copy of the most current paycheck stub
- If you have no income, we need a letter from you explaining how you are meeting your basic needs.

Please send all of the above documents to:

Methodist Medical Center of Illinois
Attn: Patient Accounts
221 NE Glen Oak Ave
Peoria, IL 61636

If you have questions about the application process, please call us at (309)672-4800.

We thank you in advance for sending us the proper information requested and for your cooperation with helping us in this matter.

Methodist Medical Center
Patient Accounts Department

**Patient's Name:** ______________________ Date of Birth: ________ SS#: ______________________

Guarantor's Name: ______________________ Spouse's Name: ______________________

Date of Birth: ______________________ Date of Birth: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

**Guarantor Marital Status:** Single Married Widowed Separated Divorced

Employer How Long? Employer: How Long?

Bus. Phone Salary: Hr. Wk. Mo. Bus. Phone: Salary: Hr. Wk. Mo.

Dependent's Name(s) Age Support (Rec'd or Pd) Dependent's Name(s) Age Support (Rec'd or Pd)

1. ______________________ 3. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

| **MONTHLY GROSS INCOME** SOURCE: | HOURLY WAGE: | #HOURS PER WEEK: | |
|---|---|---|---|
| 1. PATIENT: | $ | | $ |
| 2. SPOUSE/RESP. PARTY: | $ | | $ |
| 3. WORKING CHILDREN: | $ | | $ |
| 4. INTEREST/DIVIDEND: | $ | | $ |
| 5. PENSION: | $ | | $ |
| 6. WIDOW'S PENSION: | $ | | $ |
| 7. CHILD SUPPORT: | $ | | $ |
| 8. FOSTER CHILD INCOME: | $ | | $ |
| 9. SSI/SSDI: | $ | | $ |
| 10. RETIREMENT: | $ | | $ |
| 11. UNEMPLOYMENT BENEFITS: | $ | | $ |
| 12. OTHER: | $ | | $ |
| | TOTAL MONTHLY GROSS INCOME: | | $ |

**ASSET INFORMATION**

NAME OF BANK: BANK LOCATION:

CHECKING ACCOUNT NUMBER: AVERAGE CHECKING ACCOUNT BALANCE:

I certify that everything I have 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 check my credit and employment history and to answer any questions others may ask you about my credit record with you. I understand that I must update credit information at your request if my financial condition changes. The falsification of data may result in the reversal of any financial assistance.

Applicant's Signature: ______________________ Date: ______________________