



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 year's tax return (1040 form) including all attachments and a copy of the most current paycheck stub. If you are a Medicare patient and do not file taxes, then we will require a copy of the "monthly summary of benefits."
- If you did not file taxes, have no income and/or are receiving support from individual(s), you will need to have them complete the information below and return this to us with the application:

This is to verify that I have been supporting _____ . I have been helping him/her with: Monthly expenses/ providing room and board

Supporter(s) name : _____

Supporter(s) signatures: _____

Date signed: _____

Supporter(s) relationship to patient: _____

Supporter(s) address: _____

Supporter(s) phone number: _____

Please send all of the above documents to:
Methodist Medical Center of Illinois
Attn: Patient Accounts
221 NE Glen Oak Ave
Peoria, IL 61636

Please keep in mind that financial assistance does not apply to accounts referred to a collection agency prior to receiving your financial assistance application. As of 01/01/09, this application is for the hospital services only. If you need assistance with a Methodist Physician bill, please call (309) 672-4809.

Thank you for your assistance in getting this account taken care of in a timely manner. If you have questions about the application process, please call us at (309) 672-4800.

Methodist Medical Center – Patient Accounts Department



Patient's Name: _____
Guarantor's Name: _____
Date of Birth: _____
Address: _____

Date of Birth: _____ SS#: _____
Spouse's Name: _____
Date of Birth: _____
Address: _____

Guarantor Marital Status: Single Married Widowed
Employer How Long?
Bus. Phone Salary: Hr. Wk. Mo.

Separated Divorced
Employer: How Long?
Bus. Phone: Salary: Hr. Wk. Mo.

Dependent's Name(s) Age Support (Rec'd or Pd)
1. _____
2. _____
3. _____

Dependent's Name(s) Age Support (Rec'd or Pd)
3. _____
5. _____
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: _____
CHECKING ACCOUNT NUMBER: _____

BANK LOCATION: _____
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: _____