

GOTTLIEB MEMORIAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Patient Name : _____ Date: _____

Applicant Name: _____

How many people are in your family Unit? _____

What are the ages of each family member? _____

What members of the household are working? _____

Is any family member unable to work due to an injury? YES _____ NO _____

Is the head of the household widowed or divorced? YES _____ NO _____

If divorced do you receive or pay out alimony and/or child support?

I receive alimony and/or child support \$_____ per month

I pay alimony and/or child support \$_____ per month

Are there any other medical or financial problems that you would like us to consider?

Assets - Funds in Checking/Savings Accounts \$_____

Annual/Yearly Income \$_____

Other Income (Explain) \$_____

In order to process this application, copies of the following documents
(DO NOT SEND IN ORIGINAL FORMS) must be provided:

- 1) Last Tax Return (1040 Form) and W-2 Form
- 2) Social Security Statement if receiving Social Security benefits
- 3) Disability Statement if you are on disability
- 4) Last two pay check stubs from all employed household members
- 5) Last two Bank statements
- 6) Last two mortgage or rent receipts
- 7) Utility bills and any other bills you would like us to consider

Please return the completed Financial Assistance Application with copies of your supporting documentation to: Gottlieb Memorial Hospital

Patient Accounts Department
701 W. North Avenue
Melrose Park, IL 60160

X

X

PATIENT/GUARANTOR SIGNATURE

DATE

NOTE: BEFORE RETURNING DOUBLE CHECK THAT ALL THE DOCUMENTS THAT ARE REQUESTED ARE ATTACHED.