



Hillsboro Area Hospital
1200 E. Tremont Street · Hillsboro, IL 62049
SPECIAL FINANCIAL CONSIDERATION APPLICATION

Patient/Family Information

Responsible Party Name _____

Address: _____ Phone: _____

Employer: _____ Phone: _____

Address: _____

Spouse Employer: _____ Phone: _____

Number of Members in Family: _____

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Income Sources (Before Taxes)

Verification Required (Last Year's Taxes, Check Stubs, Social Security, Etc.)

Gross Wages-Resp. Party: _____	Gross Wages Spouse: _____
Self-Employment: _____	Public Assist./Welfare: _____
Alimony/Child Support _____	Workcomp/Unemployment: _____
Dividends/Interest: _____	Pensions/Insurance: _____
Estates/Trusts _____	Rents/Royalties: _____
Other: _____	Total Gross Income: _____

Assets

Cash Amount:\$ _____	Stocks/Bonds/Investments: _____
Name Bank/Acct#: _____	Vehicles/Year/Make: _____
Account Balance:\$ _____	Value:\$ _____
Other: _____	Total Assets: _____

I hereby state that the information given is true and complete. I authorize any required verification.

 Signature Date

(For Hospital Use Only)

Financial Summary

Total Income: \$ _____ YR.
 Last Year tax return: \$ _____ YR.
 Last three month: \$ _____ x4=\$ _____ YR.

_____ Approved _____% _____ Denied

Reviewed By: _____ Date: _____