CHARITY CARE

THE FOLLOWING ITEMS ARE NEEDED TO DOCUMENT INCOME AND ASSETS

1) A copy of the applicant's most recent tax return and W-2's.

2) A copy of all pay stubs or wage statements from employers showing all gross income for the time period since the tax return year obtained in 1) above.

3) A computer print-out from Job Service of Illinois showing all unemployment benefits received during the last 4 quarters, if any.

4) A copy of most recent bank statements for all checking, savings, and investment accounts.

5) A copy of all health care related bills outstanding to other individuals or institutions other than Thorek Hospital (e.g. physicians, emergency room, etc.)

ASSET INFORMATION

Savings account: Current balance $_____

Financial institution _____

Account number _____

Checking account: Current balance $ _____

Financial institution _____

Account number _____

Other assets:
Stocks $ _____

Company _____

Life insurance cash value $ _____

Company _____

Other $ _____

Explain _____
_____

Real property:

Auto: _____
Make Model Year Value Amount Owed

Auto: _____
Make Model Year Value Amount Owed

Residential property and other assets:

Describe: _____Value $ _____

Amount Owed _____

Other loans:

_____

_____

Name of Institution Monthly Payment Balance Purpose

_____

Name of Institution Monthly Payment Balance Purpose

_____

Charge Card Monthly Payment Balance Credit Limit

_____

Charge Card Monthly Payment Balance Credit Limit

_____

OFFICE USE ONLY:

Annual income (from tax returns, W-2's, pay stubs) $ _____

Size of family Unit _____ Poverty Guidelines X 2 _____

Information verified by: _____

Approved ( ) Denied ( )

Authorized signature (refer to Charity Care Policy):

_____

Comments:

_____

_____

_____

I understand that all information on this application will be verified by Thorek Memorial Hospital staff and that this will serve as a release for income verification and as a release to investigate my credit history. I swear that all statements in this application are true and correct and if any information is false it shall be cause for denial of this application.

Signature of Patient_____ Date _____