Jersey Community Hospital/JCH Medical Group
Application for Financial Assistance

APPLICANT INFORMATON

LAST NAME:	FIRST NAME:	DATE OF BIRTH:	SOCIAL SECURITY #: (OPTIONAL)
STREET	APT #	CITY	STATE ZIPCODE
EMPLOYER NAME:		EMPLOYER PHONE:	
EMPLOYER ADDRESS:			

CO-APPLICANT INFORMATION

LAST NAME:	FIRST NAME:	DATE OF BIRTH:	SOCIAL SECURITY #: (OPTIONAL)
STREET	APT #	CITY	STATE ZIPCODE
EMPLOYER NAME:		EMPLOYER PHONE:	
EMPLOYER ADDRESS:			

DEPENDANT INFORMATION		Lives at this address
Name:	Age:	Y / N
Name:	Age:	Y / N
Name:	Age:	Y / N
Name:	Age:	Y / N
Name:	Age:	Y / N

INCOME INFORMATION- List all household income, including rental income, Social Security, unemployment, workers compensation, alimony, child support, or any other forms of income.
** Please attach additional sheets if needed.*

DESCRIPTION of INCOME

Type of Income/Employer Name:	Received:	Gross Amount:
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$

Have you applied for Assistance through the Department of Public Aid? (Optional) Yes / No

Is so, was your application approved or denied? (Optional) Approved / Denied

I certify that all information stated in this application and on any attachments is correct. You may keep this application whether or not it is approved. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my application with any changed financial circumstances or requests for additional information/documentation. Charity Assistance may be extended to subsequent treatment subject to full disclosure of any additional financial information requested.

I understand that I can apply for Financial Assistance even if I have a pending liability/ worker's compensation claim, or an insurance claim. If it is determined at anytime the information provided is found to be false and/or inaccurate, all financial assistance will be reserved, and I will accept responsibility for the full balance due and immediate payment of any and all outstanding balances.

SIGNATURE: DATE:

Please return the completed application and requested documents to the related facility listed below:

JCH Medical Group
390 Maple Summit Road
Jerseyville, Il. 62052
618-498-7518

Jersey Community Hopsital
400 Maple Summit Road
Jerseyville, Il. 62052
618-498-8326

If you have any questions, please contact the Financial Counselor at the number listed below each facility.