In order to process your financial application, we need the following information sent to us via mail at Sherman Hospital 1425 N. Randall Rd. Elgin IL 60123Mail code GP0196 or please drop off at the hospital information desk

_____ Complete **entire** application

_____ Copy of your Social Security Benefit Letter and/or Social Security check

_____ Spouse monthly income information (if applicable)

_____ Copy of most recent check stub (s) (last four weeks)

_____ Copy of unemployment check / disability check (if applicable)

_____ Copy of last year's tax forms/W2's

_____ If there are other people living in your home, please indicate their relationship to you and what their monthly income is.

** *If they are unable to help you with your medical bills, please have them write a short letter as to why.*

_____ Indicate on the back side of the financial application what your total monthly bills are (itemized). Include your monthly rent/mortgage.

_____ If you are unemployed but not disabled, please indicate reason you are not currently working.

_____ Other**: THIS APPLICATION CANNOT BE PROCESSED WITHOUT THE NECESSARY PAPERWORK ATTACHED**

If you have any questions please contact our office

Sherman Hospital Business Office
Phone: 224.783.8715

FINANCIAL APPLICATION

Patient Last Name First MI ______ Account Number ______ Date of Service ______

Applicant	Spouse
Name Age	Name Age
Street Address	Street Address
City State Zip Code	City State Zip Code
No. Yrs. at Address____ Own___ Rent___ Married___ Single___ Separated___ Dependents No.___ Ages________________________	No. Yrs at Address____ Own___ Rent___ Married___ Single___ Separated___ Dependents No.____ Ages________________________
Name of Employer Yrs. This Line of Work___ Yrs This Job___	Name of Employer Yrs. This Line of Work___ Yrs. This Job___
Position/Title Type of Business	Position/Title Type of Business
SS# Home Phone Bus Phone	SS# Home Phone Bus Phone

GROSS MONTHLY INCOME

Applicant		Spouse	
Employment (Per Hour)	____________	Employment	____________
Social Security	____________	Social Security	____________
Net Rental Income	____________	Net Rental Income	____________
Unemployment	____________	Unemployment	____________
Child Support/Alimony	____________	Child Support/Alimony	____________
Public Assistance	____________	Public Assistance	____________
Other	____________	Other	____________
Total	____________	Total	____________

List the name of other persons living in your home that have income.
Please list amount and source of the additional income.

I/We certify that the information given is correct to the best of my/our knowledge.
Failure to provide accurate information may result in denial.

Signature of Applicant Signature of Spouse

Date: _____________

Witness: ___________________________________

OFFICE USE ONLY

Total Hospital Balances	____________	Gross Monthly Income	______________
Total Bad Debt Balances	____________	Total Family Income	______________
Total Bills To Consider	____________	Credit Bureau Date (attach copy)	_____________

Patient Representative Lead Patient Representative Collection Manager