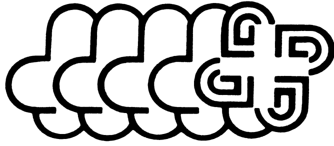
ILLINOIS RESIDENTS ONLY



Financial Assistance Application
Graham Health System

Graham Hospital
210 W. Walnut St.
Canton, IL 61520
Tele: 309-647-5240
Fax: 309-649-5110

Graham Medical Group
175 S. Main St.
Canton, IL 61520
Tele: 309-647-0201
Fax: 309-649-5302

Applicant's Name:______________________________ Spouse/Partner:______________________________

Address:____Apt. #:____________

P.O. Box:__________________

City:____ State:________ Zip:____________________

Phone number:______________________________

Daytime phone number:_______________________

Employer:__________________________________

Names of other individuals under age 18 living in the household: (Please include last names)

____ ____

____ ____

____ ____

Total Household Income includes SS/SSI, Unemployment, Disability, Pension, Alimony/Child Support, Investment Income and Other Income

<u>Total Household Income</u>

Last 30 days:______________________________

<u>Total Household Income</u>

Last Tax year:______________________________

Income must be verified by a copy of your most recent pay stub and a copy of your most recent federal income tax form. ***Please attach these documents.***
If no income, how do you pay for your living expenses?__________________________________

Assets
Checking/Accounts:_____________________________ Account Balance & Date: $____________________
(List Name & Address of Institution)
Checking/Accounts:_____________________________ Account Balance & Date: $____________________
(List Name & Address of Institution)
Savings/Money Market/CD Accounts:_______________ Account Balance & Date: $____________________
(List Name & Address of Institution)
Savings/Money Market/CD Accounts:_______________ Account Balance & Date: $____________________
(List Name & Address of Institution)

Do you own your home? ___Yes ___No Amount owed: $____
Do you rent your home? ___Yes ___No If yes, monthly payment $________________________________
Do you own other property? ___Yes ___No If yes, describe__________________ Amount owed $__________

List other assets owned including vehicles (cars, trucks, boats, trailers, etc.)
____ Amount owed $_____________________________
____ Amount owed $_____________________________
____ Amount owed $_____________________________

<u>Other</u> (List any other circumstances you would like us to consider):

Graham Health System reserves the right to reverse any charity assistance in the event that you falsified data or failed to disclose financial information on your application for charity assistance. If there is a pending liability claim, workman's compensation claim, or insurance claim, charity assistance cannot be applied, or may be reversed at anytime. You must inform a Financial Counselor, in writing, of any changes in your financial circumstances affecting your ability to pay any balance due from you.

I certify that everything stated in this Application and on any attachment 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.

Signature:____ Date________________

For Internal Use Only:

Guideline:________________ Other info:____

Account(s): ______________ ________________ ________________ ________________

Amount(s): ______________ ________________ ________________ ________________

Eligible:________ Ineligible:________ Date:__________ By______________________________

Partial eligibility:________ Balance due after reduction:________________________

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Date:	#:	$:		Date:	#:	$:	
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