ROCKFORD HEALTH system

IT'S CALLED COMMITMENT

Date ______________________________
Patient Account No. _______________
RHS Representative _______________

FINANCIAL DISCLOSURE SHEET

(Please print or type)

As part of our commitment to our community, Rockford Health System provides financial assistance to individuals with limited financial resources who meet established eligibility criteria. This Financial Assistance Application will gather information about you and all other members of your household that will help us make an appropriate determination of your eligibility for financial assistance. In order to accurately assess your payment ability, we ask that you provide us with copies of your most recent IRS 1040 Income Tax Return; W2s (including all schedules); the last two paycheck stubs for all working household members; and copies of patient statements for healthcare balances owed to Rockford Health System or other providers. We have enclosed a return envelope for your convenience. Please return by ______________________________

Patient Name: ______________________________ Social Security No. ____________________
Birthdate: ______________________________ Phone Number: ____________________
Guarantor Name: ______________________________ Social Security No. ____________________
Birthdate: ______________________________ Phone Number: ____________________
Address: ____
Number City State Zip
Employer: ____ Years Employed: ________
Employer's Address/Phone ____
Number City State Zip Phone
Spouse's Name: ______________________________ Social Security No. ____________________
Birthdate: ______________________________ Phone Number: ____________________
Spouse's Employer: ____
Employer's Address/Phone ____
Number City State Zip Phone

Checking Account(s)

Name on Account	**Number**	**Bank**	**Current Balance**
			$
			$

Savings Account(s)

Name on Account	**Number**	**Bank**	**Current Balance**
			$
			$

Credit Card(s)

Credit Card Name	**Credit Limit**	**Current Balance**	**Monthly Payment**
	$	$	$
	$	$	$
	$	$	$
		Total	$

OVER

Revised 10/04; 03/05; 08/07

Net Income	**Per Month**	**Additional Income**	**Value/Balance**	**Contribution**
Guarantor	$__________	I R A / CD	$___________	$______________
Spouse	$__________	401 K PLAN	$___________	$______________
Other (describe)	$__________	SOCIAL SECURITY	$___________	$______________
Total Income	$__________	WORKERS COMP	$___________	$______________
	$ __________	PENSION	$___________	$______________
		OTHER	$___________	$______________

Identify and list number of dependents as shown on tax return: ________

NAME	**AGE**	**RELATIONSHIP**
1.____________________	____________	__________________________
2. ____________________	____________	__________________________
3. ____________________	____________	__________________________

Expenses:	**Per Month**
Rent/Mortgage	$______________
Home Equity Value $___________	$______________
Car(s) Make Year Model	
____________________________	$______________
____________________________	$______________
Food	$______________
Gasoline for Transportation	$______________
• Heat	$______________
• Electric	$______________
• Telephone/Cell	$______________
• Auto Insurance	$______________
• Cable	$______________

Other Expenses: (Please List)

__________________________	$______________
__________________________	$______________
__________________________	$______________

By signing below, you certify on behalf of yourself and your household to Rockford Health System\, and authorize Rockford Health System to proceed, as follows:

1. The information provided on this Application is true, accurate and complete to the best of my knowledge;
2. Rockford Health System may obtain a personal credit bureau report to verify outstanding financial obligations;
3. Rockford Health System has the right to verify all information provided with this application, including through communications with third parties; and
4. No member of my household carries any insurance that would pay for any portion of any financial obligation we may have to Rockford Health System; OR, we have provided all relevant information regarding our insurance to Rockford Health System.

_________________________________ ___________________

Patient/Guarantor Signature Date

_________________________________ ___________________

Spouse's Signature Date

By your signature above you authorize Rockford Health System to obtain a personal credit bureau report to verify outstanding financial obligations.