

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
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Spouse's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Employer's Address/Phone \_\_\_\_\_

	Number	City	State	Zip	Phone
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**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**

<u>Net Income</u>	<u>Per Month</u>	<u>Additional Income</u>	<u>Value/Balance</u>	<u>Contribution</u>
Guarantor	\$ _____	IRA / 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: \_\_\_\_\_

	<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
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.