

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

| <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.