



**Application for JCH Financial Assistance Program
Hospital Services Only (Please Type or Print)**

Jersey Community Hospital

Instructions: Complete the application in full, sign the authorization to verify information and submit with latest Federal Tax Return Form 1040 and current pay stub, unemployment compensation, Social Security or other income.

Applicant Information

Last Name	First	M.I.	Date of Birth	Social Security Number	# of Dependents
Street	Apt #	City	State	Zip	Home Phone
Employer	Position				Cell Phone
Employer Address	City	State	Zip	Work Phone	

Co-Applicant – Must complete if you rely on the income of another person(s)

Last Name	First	M.I.	Date of Birth	Social Security Number	Relationship
Employer	Position				Cell Phone
Employer Address	City	State	Zip	Work Phone	

Dependent Information

Name	Age	Live at above address	Name	Age	Live at above address
		Yes No			Yes No

Income Information – List all household income, include rental income, Social Security, unemployment, worker’s compensation, alimony, child support or other forms of income. Attach additional sheet if more lines are needed. Provide copies of last pay stubs or income records and most recent Federal tax return with W-2’s

Description of Income	Paid To	Gross Amount (before taxes/deductions)
___ Weekly ___ Bi-Weekly ___ Monthly		
___ Weekly ___ Bi-Weekly ___ Monthly		
___ Weekly ___ Bi-Weekly ___ Monthly		
___ Weekly ___ Bi-Weekly ___ Monthly		

Assets/Banking Information	Checking Account	Bank Name	Savings Account	Bank Name
Auto(s)	Year	Make Model	Year Purchased	Tax Assessed Value
				Loan Balance
	Year	Make Model	Other Real Estate	
	Year	Make Model	RV/Boat	

Monthly Expenses	Rent/Mortgage	Utilities	Water/Sewer	Telephone
Groceries	Auto Payment(s)	Auto Insurance	Health Insurance	Property taxes not included in Mortgage
Other (Describe)	Other (Describe)		Other (Describe)	
Other (Describe)	Other (Describe)		Other (Describe)	
Other (Describe)	Other (Describe)		Other (Describe)	

Have you applied for Assistance through the Department of Public Aid? Yes / No Approved / Denied **Have you previously received a Charity write off from Jersey Community Hospital? Yes / No Dates? _____**

I certify that all information stated in this Application and on any attachments 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 or requests for additional information/documentation. Charity Assistance may be extended to subsequent treatment subject to full disclosure of any additional financial information requested.

I understand that I can not apply for if I have a pending liability claim, worker’s compensation claim, insurance claim. If it is determined at anytime the information I provided is found to be false and/or inaccurate, all Charity care will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

I also agree to accept payment responsibility according to the terms and conditions of JCH for any amount due after any partial assistance may be awarded.

Signature: _____ Date: _____

Please return completed application and requested documentation to: **Jersey Community Hospital/Business Office
400 Maple Summit Road
Jerseyville, IL 62052**

Questions? Call (618) 498-8326