Jersey Community Hospital/JCH Medical Group
Application for Financial Assistance

APPLICANT INFORMATON

LAST NAME	FIRST NAME	DATE OF BIRTH	SS NUMER-**OPTIONAL**

STREET	APT #	City	State	Zip

Employer Name	Employer Phone
Employer Address:	

CO-APPLICANT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SS NUMER -**OPTIONAL**

STREET	APT #	City	State	Zip

Employer Name	Employer Phone
Employer Address:	

DEPENDANT INFORMATION			Lives at this address
Name	Age		Y/N
Name	Age		Y/N
Name	Age		Y/N
Name	Age		Y/N
Name	Age		Y/N

INCOME INFORMATION-List all household income, include rental income, Social Security, unemployment, workers compensation, alimony, child support or other forms of income. Attach additional sheets if needed.

DESCRIPTION of INCOME

Type of Income/Employer Name	Received	Gross Amount
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$
	W/Bi-W/Monthly	$

Have you applied for Assistance through the Department of Public Aid?	Yes/No

Is so, was your application approved or denied?	Approved/Denied	Please circle on

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 apply for Financial Assistance even if I have a pending liability/ worker's compensation claim, or an insurance claim. If it is determined at anytime the information provided is found to be false and/or inaccurate, all financial assistance will be reserved, and I will accept responsibility for the full balance due and immediate payment of any and all outstanding balances.

Signature Date

Please return completed application and requested documents to the realted facility:

JCH Medical Group
390 maple Summit Rd
Jerseyville, Il 62052
618-498-7518, ext. 211

Jersey Community Hopsital
400 Maple Summit Rd
Jerseyville, Il 62052
618-498-8326

If you have any questions, please contact the accounts representaive at the number listed below the facility.

11/2/2023