St. Anthony's Memorial Hospital
503 North Maple Street
Effingham, Illinois 62401

Christian Care Financial Assistance Application

St. Anthony's Memorial Hospital offers financial assistance to patients in need. Guidelines have been established to ensure the Hospital's limited resources are used to treat patients who are truly unable to pay and are not consumed by patients unwilling to pay or who have alternate pay sources.

CONFIDENTIAL FINANCIAL STATEMENT

Please complete this form, sign and date it and have a witness sign it. Then return to Christian Care Financial Assistance, Business Office, St. Anthony's Memorial Hospital, 503 N. Maple St., Effingham, IL 62401

Patient's Name ______________________ Social Security Number ______________

Address ______________________ Date of Birth ______________

City, State, Zip ______________________ Phone Number ______________

Guarantor's Name ______________________ Social Security Number ______________

(Person responsible for bill, if other than patient)

Address ______________________ Phone Number ______________

City, State, Zip ______________________ Alternate phone number ______________

(cell, work, etc)

Marital Status Single Married Separated Divorced Widow(er) Other

Please circle - if other, please explain

Number of people in the household [ ]

Includes ALL individuals living in a single residence

Students at college or prep school should be included if household provides support

DEPENDENTS - Name	Relationship	Date of Birth

For additional dependents, please attach on a separate sheet of paper

Principal Residence - Own - Rent - Other

If Rent - Name of Landlord ______________________ Rent Amount $ ______

Address ______________________

City, State, Zip ______________________

If other, please explain

Example, live with parents, friend, in college, etc.

INCOME - include All Household Members

Wages - Current year W-2 and three check stubs/pay vouchers required

Name ______________________________ Indicate how paid and amount

Employer ______________________________ Hourly, Monthly, Annual

Address ______________________________ Other - Please explain

City, State, Zip ______________________________ $

- Employment Dates _____________ to __________
  (Month/Year) (Month/Year)

Name ______________________________ Indicate how paid and amount

Employer ______________________________ Hourly, Monthly, Annual

Address ______________________________ Other - Please explain

City, State, Zip ______________________________ $

- Employment Dates _____________ to __________
  (Month/Year) (Month/Year)

If multiple employers during year, list employers and wages on separate sheet of paper

Income Source	Amount
Farm or Self-Employment - Include applicable tax schedules	$___________
Public Assistance - Includes food stamps, circuit breaker, etc.	$___________
Unemployment Compensation - Indicate length of time, expected return date, expectations of future employment	$___________
Workers Compensation - Indicate length of time, expected return date expectations of future employment	$___________
Housing Allowance - Rent-free housing provided by employer or organization	$___________
Other Allowances - Vehicles, utilities, food, etc. provided by employer or organization	$___________
Child Support	$___________
Alimony	$___________
Military Family Allotment	$___________
Pensions - Source	$___________
Interest, Dividends, etc - Source (include supporting documents)	$___________
Rent Income - Include rent expenses applicable to income	$___________
Social Security Benefits	$___________
Other Income	$___________
______________________________	$___________
______________________________	$___________
______________________________	$___________
- Indicate source	

ASSETS

Please indicate asset value and any amounts that are still owed.

	Asset Value	Amount Owed	Monthly Payment
1. Value of Principal Residence	$	$	$
2.* Value of Secondary Residence Indicate type of residence and address Cabin, Vacation Home, Condo, Time Share, etc.	$	$	$
3.* Value of other property Indicate type of property and address Rental property, Lots, Farm Ground, Investment Property, etc.	$	$	$
4. Vehicles: 1 - Year _______ Make: ______________	$	$	$
2 - Year _______ Make: ______________	$	$	$
3 - Year _______ Make: ______________	$	$	$
4 - Year _______ Make: ______________	$	$	$
5.* Boats, Recreational Vehicles, Motorcycles, ATV's, Jet Skis, Campers, etc. Please indicate type of vehicle	$	$	$
6. Savings account balance Institution -	$		
7. Checking account balance Institution -	$		
8.* Investments Stocks, Bonds, CD, 401k, IRA's, etc. Indicate source	$		
9.* Other assets Includes farm and business equipment, etc. Indicate asset	$	$	$

* Items 2, 3, 5, 8 and 9 - Please provide a description of these items on a separate sheet of paper

EXPENSES - For debts not listed elsewhere on application	To whom owed	Amount Owed	Monthly Payment
Utilities			
Electric			
Gas			
Telephone - House			
Telephone - Cell			
Trash			
TV/Cable			
Water			
Sewer			
Food			
Medical Bills			
- Physician and/or facility name			
Hospitals			
Physicians			
Dentist			
Other			
Credit Cards			
Indicate if balance is medical			
Property Taxes			
Insurance			
Gas/Vehicle Maintenance			
Other Debt			

* If additional debt, please include on a separate page

This is to advise that I have pursued all other avenues possible, including private insurance and governmental and charitable agencies providing funding and relief from financial obligations, as well as Public Aid, Therefore, I hereby request that St. Anthony's Memorial Hospital make a determination of my eligibility for their Christian Care Financial Assistance Program. I understand that the information that I submit concerning my income, household size, assets, expenses and medical bills is subject to verification by St. Anthony's Memorial Hospital personnel. I also understand that if the information that I submit is now or at any time in the future is determined to be false, such a determination will result in current and/or retroactive denial of financial assistance and that I will be liable for services rendered.

I further understand that this financial information will not be shared with anyone outside of the hospital without my written authorization.

I certify that all of the information in this form is true and correct

Signature________________________________ Date _________

Witness ________________________________ Date _________

Effective date 06/01/2004