Patient Account Services For:
Midwestern Regional Medical Center
2520 Elisha Ave.
Zion, Illinois 60099

INCOME, ASSET & LIABILITY WORKSHEET

In accordance with the IL Fair Patient Billing Act, in order to apply for Financial Assistance with your medical service billings; please accurately and truthfully complete the attached worksheet and return it along with the requested supporting documentation.

NOTE: A copy of your credit report may be accessed in order to conduct our review. Any incomplete worksheets or lack of required supporting documentation will result in your application being returned to you.

Mail your application to:

Patient Accounts
2610 Sheridan Rd. – 2nd Floor
Zion, IL. 60099

Once the worksheet and supporting documentation have been returned to the Patient Accounts department; both your hospital and physician balances will be submitted for review. The Financial Assistance committee will review your application. Upon the committee's determination you will be notified of the outcome.

If you have additional questions concerning the application process, please contact the Patient Accounts Department at 800.552.1161.

Thank you.

Patient Accounts for Services Rendered At:

MIDWESTERN REGIONAL MEDICAL CENTER

INCOME, ASSET & LIABILITY WORKSHEET

Date: ____________________

Patient Name: __________________________________ **Phone #:** __________________________

Date of Birth: __________ **Marital Status:** ______ **Number of Dependents:** _________

Patient Social Security #: ______________________ **Spouse Soc. Sec. #:** ____________________

<u>A copy of your most recent tax return must be included with this application.</u>

Liquid Assets:

Savings/Check Account: ____________________/____________________
Certificates of Deposits: ____________________/____________________
Stocks/Bonds: ____________________/____________________
Other: ____________________/____________________

TOTAL: __________________________

Real Estate:

Home (Fair Market Price): __________________________
Home (Equity): __________________________
Other:________________ __________________________

Personal Property:

Car(s): __________________________
Other: _______________ __________________________
_______________ __________________________

Patient Employment Status: - Circle One

Active Employee Retired Disabled Employee
(Full Time / Part Time)

Employer Name, Address & Phone #:

____
____
____

Income, Asset & Liability Worksheet for: ______________________________

Spouse Employment Status: - Circle One

Active Employee   Retired   Disabled Employee
(Full Time / Part Time)

Employer Name, Address & Phone #:

____
____
____

Total Household Monthly Income: -
(Copy of check(s)/check stub(s) or proof of direct deposit required)

1st (list highest income here): ______________________________
2nd: ______________________________
List all other sources of income: ______________________________
__________________ ______________________________

Monthly Expenses:
- (Verification required, copies/receipts are accepted.)

Rent: ______________________________
Mortgage: ______________________________
2nd Mortgage: ______________________________
Property Taxes: ______________________________ (if not included in mortgage)
Electricity: ______________________________
Water: ______________________________
Gas: ______________________________
Phone: ______________________________
Food: ______________________________
Medications: ______________________________
____
Insurance:
(please specify type)
_________________ ______________________________
_________________ ______________________________

Car Payment(s): ______________________________
____

Other Payments:
(please specify type)
_________________ ______________________________
_________________ ______________________________

Income, Asset & Liability Worksheet for: ____________________________

Credit Cards - Please list all:

Credit Card Name	Credit Limit	Total Bal. Due	Mo. Pymt.
__________________	____________	_____________	____________
__________________	____________	_____________	____________
__________________	____________	_____________	____________
__________________	____________	_____________	____________

Bank Payments/Loans - Verification required:

Bank Name: ______________ Last Pymt. Date:_____ Loan Amt./Mo. Pymt. ______/______

Bank Name: ______________ Last Pymt. Date:_____ Loan Amt./Mo. Pymt. ______/______

Briefly describe any other circumstances or financial obligations you may have that have not been outlined in the application above: __________________

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The undersigned agrees that the above listed information is true and accurate.

Signed: ______________________ Date: __________________

This application is considered a request for financial assistance. This application does not replace your obligation for payment. It is important that your accounts be kept current. Please continue your monthly payments while your application is under consideration. You will be notified of the outcome once the committee has completed its review.

Please return all information to:
Patient Accounts 2610 Sheridan Rd. – (2nd Floor) Zion, IL 60099.
Attn.: _____________________________