

REQUEST FOR ASSISTANCE ON MEDICAL BILL

I hereby request that Silver Cross Hospital make a written determination of my eligibility for uncompensated services at Silver Cross Hospital. I understand that the information which I submit concerning my annual income and family size is subject to verification by Silver Cross Hospital. I also understand that if the information that I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

****This application will not be approved without proof of income. Please attach copies of last year's income tax return, W2 Forms and current check stubs. *****Please return in 14 days.

1. NAME _____ PHONE _____

2. ADDRESS _____

3. EMPLOYER: _____ OCCUPATION _____

EMPLOYER ADDRESS: _____ # OF EMPLOYEES _____

4. INCOME: List income for family from : Last 3 Months Last 12 Month

Wages	_____	_____
Farm or Self-Employment	_____	_____
Public Assistance	_____	_____
Social Security	_____	_____
Unemployment Compensation	_____	_____
Strike Benefits	_____	_____
Workmen's Compensation	_____	_____
Alimony/Child Support	_____	_____
Military Family Allotments	_____	_____
Pensions	_____	_____
Income from Dividends, Interest, Rent	_____	_____

How many in family:
Name/Relationship/Age _____

I affirm that the following information is true and correct to the best of my knowledge.

Signature Date