



Dear Patient

Illinois Valley Community Hospital affirms and maintains its commitment to serve our community in a manner consistent with our mission, vision, and value statements. These statements emphasize our commitment to meet the healthcare needs of our community through the provision of quality patient care. Within the limits of our resources, the use of our facility's services and efforts will be provided to aid all persons, regardless of their financial resources.

The inside form must be completed and signed by you. We use income guidelines established by the U.S. Dept. of Health and Human Services to determine if you are eligible for charity care. We do verify assets regarding your eligibility. So, please provide all the information promptly so we may try to help you as quickly as possible.

If you have any questions about IVCH Financial Aid or any other offers of assistance, please call our Billing Department or the Patient Accounting Supervisor at (815) 780-3418.

Sincerely,
The Caring Professionals of
Illinois Valley Community Hospital

**For Illinois Valley Community Hospital
USE ONLY**

Date Appl. Sent: _____ Returned: _____


Approved %: _____
Amount: _____

Denied: _____
Reason: _____

Signed: _____
Title: _____
Date: _____



- In order to qualify for assistance, you must:
- complete an application form (we'll help if necessary)
 - provide documentation of income for the last 12 months, including federal tax form 1040 and the last three pay stubs for all household members
 - provide evidence that you have pursued all other payment sources, including public aid
 - bank statement for the last two months for all household members



FINANCIAL AID PROGRAM

RETURN APPLICATION TO:

Illinois Valley Community Hospital
 925 West Street
 Peru, IL 61354
 ATTN: Patient Accounting Supervisor

Illinois Valley Community Hospital

Financial Assistance Application

| | | |
|------------------|---------|--|
| Patient Name: | SS# | |
| Patient Address: | Phone # | |

| | Head of Household | | Spouse |
|---|-------------------|--|--------|
| Name | | | |
| Address - Street, City, State, & Zip Code | | | |
| Home Phone # | | | |
| Social Security # | | | |
| Date of Birth | | | |
| Employer | | | |
| Employer's Phone # | | | |
| Hire Date | | | |
| Salary/Hourly Wage | | | |
| # Hours Worked/Week | | | |
| Gross Annual Wages | | | |

Total Number of Dependents that can be claimed on income tax form: _____
 (Please write name and date of birth for each child that can be claimed)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Other Monthly Income:

Social Security: _____ Rental Property: _____
 Interest/Investment: _____ Child Support/Alimony: _____
 Other Income: _____

Total Household Gross Income: _____

Assets: (List Name & Address of each Institution)

Checking Account: _____ Balance: _____
 Savings Account: _____ Balance: _____
 CD/IRA/Stocks & Bonds: _____ Balance: _____
 Other: _____ Balance: _____
 _____ Balance: _____
 _____ Balance: _____

Signature - I certify that everything I have stated in this application and any attachments included is correct. You may keep this application whether or not it is approved. By signing below, I have authorized you to check my credit and employment history and I will answer questions required. I understand that I must update credit information at IVCH's request. The falsification of data may result in the reversal of any financial assistance.

Signature: _____

Date: _____