



FINANCIAL APPLICATION
PATIENT FINANCIAL SERVICES
2300 CHILDREN'S PLAZA, BOX #44
CHICAGO, ILLINOIS 60614
TELEPHONE: 877. 924.8200
FAX: 312. 573.4598

PATIENT NAME: _____ **DATE:** _____

PATIENT'S DATE OF BIRTH: _____

GUARANTOR NAME: _____ **ACCOUNT #:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

To better help you meet your financial responsibilities, it is necessary that you complete the Financial Application in its entirety. Please submit the application with the requested documents. For a list of documents, please refer to the second page.

| PERSONAL INFORMATION | |
|--|-------------------------|
| Mother's Name: | Mother's Occupation: |
| Father's Name: | Father's Occupation: |
| Patient's Name: | Patient's Occupation: |
| Legal Guardian's Name: | Guardian's Occupation: |
| Number of Dependents: | |
| ASSETS AND INCOME | |
| Assets: | Monthly Income: |
| Savings: | Father: |
| Checking: | Mother: |
| Other: | Other: |
| | Child Support: |
| | Social Security: |
| Total: | Total |
| NET MONTHLY EXPENSES FOR NECESSITIES | |
| Rent: | Electricity: |
| Mortgage: | Gas: |
| Group/Private Health Insurance Premiums: | Telephone: |
| House/Rental Insurance: | Water: |
| Other: | Food Payment: (average) |

| | |
|-----------------------------|---------------------------------------|
| Car Payments # of Vehicles: | Child Care/School Tuition: |
| Car Insurance: | Transportation: (CTA, PACE, METRA) |
| | Total Monthly Expenses: |

LIST MEDICAL EXPENSES INCURRED DURING THE PAST 12 MONTHS

| Hospital/Physician | Current Balance | Total Debt |
|--------------------|-----------------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

OTHER EXPENSES

| Description | Monthly Payment | Balance |
|-------------|-----------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

In order for Children's Memorial Hospital to help you meet your financial needs, please include last year's income tax returns (e.g. W2 and 1040), paycheck stubs for each parent who is employed for past 3 months (or a letter from the employer if paid in cash), and supporting documents for other income. I

I certify that to the best of my knowledge all information is true and correct.

Signature: _____ Date: _____

Reminder: This Financial Application must be completed in order to give consideration for financial assistance. If you need assistance completing this form, please contact Customer Service at 877. 924.8200.