Financial Assistance Application

Applicant's Name: _____ _____
(Last Name) (First Name) (MI) (Birth Date) (Soc Sec #- optional)

Address: _____
(Street Address) (City) (State) (Zip Code)

Cell Phone: (_____) _____ Home Phone: (_____) _____

Insurance: _____ID #:_____ Subscriber Name:_____
(Company Name)

The following questions regarding race, ethnicity, sex, and preferred language are OPTIONAL, and responses or non-responses will not have any impact on the outcome of the application

Race: □ American Indian or Alaskan Native □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Sex: □ Male □ Female
Preferred Language: □ English □ Spanish □ Polish □ Chinese □ Arabic □ Russian □ Urdu

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Number of individuals within your household that you are responsible for: _____

Number of dependents claimed on your taxes:____ Is Anyone else employed within your household?: ___

People living in your household, including applicant:

Household Member's Name and Birth Date (if more than 3, list on separate page)	**Salary**	**Household Member's Employer**

Presumptive Eligibility				
Please mark all that apply. If you have checked one or more boxes, you only need to submit your approval letter from the appropriate state department. No further financial documentation is needed.				
□ Illinois Medicaid (Title XIX)	□ SNAP or WIC	□ Low Income Home Energy Assistance Program (LIHEAP)	□ Illinois Free Lunch and Breakfast Program	□ Homeless

If none of the above presumptive eligibility categories apply, please review and attach the appropriate documentation upon return of this application.

Please provide the following information for **each** applicable family member and sign the certification statement below:

1) Copy of most recent Federal tax return (1040) –Include all pages

2) Copy of the most recent W2's

3) Copy of three months' pay stubs for all employed family members or self-employment income and expenses

4) Copy of three months' checking and/or savings bank statements

5) If applicable, copy of Social Security Disability Award letter

6) If applicable, copy of Unemployment Statement or Workers' Compensation Award

7) Other income/asset sources (i.e. child support, alimony, pension, stocks, bonds, mutual funds, CD, other retirement income, cash and/or letter from employer - if paid in cash, etc.)

1000 Medical Center Drive, Monticello, IL 61856
Phone: (217)762-1540 Fax: (217)762-1542
Kirbyhealth.org

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I/We hereby certify that I/We are of legal age and that the foregoing statements are true and complete and are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain your property, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made herein.

_____ _____

Applicant's Signature: Date:

_____ _____

Co-Applicant's Signature: Date:

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