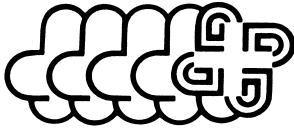


Fulton County Residents Only



Financial Assistance Application

Business Services

Graham Hospital

210 W. Walnut Street

Canton, IL 61520

Voice: 309-647-5240 Fax: 309-649-5110

Applicant's Name: _____ Spouse/Partner: _____

Address: _____ Apt. #: _____

P.O. Box: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Daytime phone number: _____

Employer: _____

Names of other individuals under age 18 living in the household: (Please include last names)

_____	_____
_____	_____
_____	_____

Total Household Income includes SS/SSI, Unemployment, Disability, Pension, Alimony/Child Support, Investment Income and Other Income

Total Household Income

Total Household Income

Last 30 days: _____

Last Tax year: _____

Income must be verified by a copy of your most recent pay stub and a copy of last year's tax form. *Please attach these documents.*

If no income, how do you pay for your living expenses? _____

Assets

Checking/Accounts: _____ Account Balance & Date: \$ _____
(List Name & Address of Institution)

Checking/Accounts: _____ Account Balance & Date: \$ _____
(List Name & Address of Institution)

Savings/Money Market/CD Accounts: _____ Account Balance & Date: \$ _____
(List Name & Address of Institution)

Savings/Money Market/CD Accounts: _____ Account Balance & Date: \$ _____
(List Name & Address of Institution)

Do you own your home? Yes No Amount owed: \$ _____

Do you rent your home? Yes No If yes, monthly payment \$ _____

Do you own other property? Yes No If yes, describe _____ Amount owed \$ _____

List other assets owned including vehicles (cars, trucks, boats, trailers, etc.)

_____ Amount owed \$ _____

_____ Amount owed \$ _____

_____ Amount owed \$ _____

Graham Hospital reserves the right to reverse any charity assistance in the event that you falsified data or failed to disclose financial information on your application for charity assistance. If there is a pending liability claim, workman's compensation claim, or insurance claim, charity assistance cannot be applied, or may be reversed at anytime. You must inform our Business Office, in writing, of any changes in your financial circumstances affecting your ability to pay any balance due from you.

I certify that everything stated in this Application and on any attachment is correct. You may keep this Application whether or not it is approved. By signing below, I authorize you to verify all information submitted. I agree to immediately supplement my Application with any changed financial circumstances.

Signature: _____ **Date** _____

For Internal Use Only:

Guideline: _____ Other info: _____

Account(s): _____

Amount(s): _____

Eligible: _____ **Ineligible:** _____ **Date:** _____ **By** _____

Partial eligibility: _____ **Balance due after reduction:** _____

Date: _____ #: _____ \$: _____	Date: _____ #: _____ \$: _____
Date: _____ #: _____ \$: _____	Date: _____ #: _____ \$: _____
Date: _____ #: _____ \$: _____	Date: _____ #: _____ \$: _____
Date: _____ #: _____ \$: _____	Date: _____ #: _____ \$: _____
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