



Financial Assistance Program Application

I have no health insurance.

My family Household Gross Annual
Income is \$_____.

My family size is _____.

Patient Name/Account Number(s):

Guarantor Name and Address:

Phone:

Patient/Guarantor Signature Date

Attachments

- _____ Past 3 months earnings statements.
- _____ Most recent Federal Tax Return.
- _____ Statement of Assets.
- _____ Past 3 months bank statements.

Where to send your completed application and required attachments:

Business Office Manager
St. Joseph's Hospital
9515 Holy Cross Lane
P. O. Box 99
Breese, Illinois 62230