



Norwegian American Hospital  
1044 N. Francisco Avenue  
Chicago, IL 60622

### **Patient/Guarantor Financial Statement**

INSTRUCTIONS: Please complete all information on the following application. Send the financial statement back to the hospital with the following documents, last months bank statement, last months rent receipt, last months utility bills, last months pay stubs and last years tax return. If someone is providing room and board or is helping to pay your bill a letter of support will need to be sent in with this financial statement.

Patient Account # \_\_\_\_\_

Guarantor Name \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Alternate \_\_\_\_\_

Number of family members in home \_\_\_\_\_

Total household income \_\_\_\_\_

Mortgage/Rent \_\_\_\_\_

Electric Bill \_\_\_\_\_ Water \_\_\_\_\_ Gas \_\_\_\_\_

Garbage \_\_\_\_\_ Phone \_\_\_\_\_

Auto Loans \_\_\_\_\_ Auto Ins \_\_\_\_\_

Medical Bills \_\_\_\_\_ Medical Ins \_\_\_\_\_

Credit Cards \_\_\_\_\_

Food \_\_\_\_\_

Total Monthly Debts \_\_\_\_\_



**Please Check Yes or No**

Home Yes ( ) No ( ) Assessed Value \_\_\_\_\_

2<sup>nd</sup> Home/Property Yes ( ) No ( ) Assessed Value \_\_\_\_\_

Life Ins Policy Yes ( ) No ( ) Cash Value \_\_\_\_\_

Checking Yes ( ) No ( ) Balance \$ \_\_\_\_\_

Savings Yes ( ) No ( ) Balance \$ \_\_\_\_\_

Money Market, IRA's, CD's, Stock's, Bonds Yes ( ) No ( )

Cash Value \$ \_\_\_\_\_

Automobiles Yes ( ) No ( )

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

I understand that if I have given false information or intentionally failed to disclose information, hospital financial assistance may be denied.

**Note that failure to provide all the required documents within the next 21 days can result in a delay in processing, denial of your request and/or your account resuming the normal collection process.**

Signed \_\_\_\_\_ Date \_\_\_\_\_