

*Illinois Valley Community Hospital*  
925 West Street  
Peru, IL  
815-223-3300

## Uninsured Discount Application

Name: (Last) \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_ Home phone: \_\_\_\_\_ Work #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Length of employment: \_\_\_\_\_ Spouse: \_\_\_\_\_

Salary: (Gross) \_\_\_\_\_ (monthly) Spouse: (Gross) \_\_\_\_\_ (monthly)

Bank Name: \_\_\_\_\_ Checking \_\_\_\_\_ Savings \_\_\_\_\_ CD \_\_\_\_\_

Do you own or rent? \_\_\_\_\_ Monthly payment \$ \_\_\_\_\_

Other monthly income: \_\_\_\_\_ Amount: \_\_\_\_\_

Number of exemptions claimed on IRS 1040: \_\_\_\_\_

**ATTACHMENTS REQUIRED:** \_\_\_ 2008 IRS 1040 (complete) or  
\_\_\_ Last two pay stubs \_\_\_ Last two months bank statements

I certify that everything stated in this application and all attachments are true and complete. By signing below, I authorized IVCH to check my credit and employment history and I will answer any questions required. I understand that I must update this information at the request of IVCH. The falsification of data may result in the reversal of any financial assistance.

Signature: \_\_\_\_\_ Spouse: \_\_\_\_\_

Date: \_\_\_\_\_