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KANE COUNTY HOSPITAL
Healing Happens Here

Sliding Fee Scale Application

Medically urgent care only. Administration will determine urgency.

NAME: _____ SSN:_____

ADDRESS: _____

TELEPHONE: (DAY) _____ (EVENING) _____

INCOME FOR THE LAST 12 MONTHS

Employment Income _____ Royalties Income _____
Rental Income _____ Royalties _____
Alimony _____ Child support _____
Unemployment _____ Social Security _____
Other Income (explain):_____

DEPENDENTS: Spouse & any living at home under age 18 or child living at home and attending school under age 21. Dependents will be verified by your Federal Income Tax Returns.

DEPENDENTS NAME	AGE	RELATIONSHIP

CASH ACCOUNTS: List all accounts in your name & the name of any dependent

FINANCIAL INSTUTION	OWNER NAME	ACCOUNT TYPE	ACCOUNT BALANCE

OTHER ASSETS: List all property owned by you or your dependents. Assets include house, land, automobiles recreational vehicles, livestock, life insurance, satellite dish, mineral rights, tools, equipment, etc.

TYPE OF PROPERTY	MODEL & YEAR	OWNER NAME	VALUE	OWED

Have you ever applied for Charity Care from this facility before? ☐**Yes** ☐ **No** If so, what approximate date? _____
Everything I have stated in this application is correct to the best of my knowledge. I understand that Kane County Hospital is authorized to verify my employment history and balance listed above.

_____ _____ _____ _____
(APPLICANT'S SIGNATURE) **(DATE)** **(CO-APPLICANTS SIGNATURE)** **(DATE)**

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DOCUMENTATION NEEDED FOR SLIDING FEE SCALE APPLICATION

1 Copy of current year tax return (all schedules)

2 Proof of income for the past **three** months (check stubs, unemployment records, bank statements etc).

Please send *copies* or bring in with the Sliding Fee Scale Application

Applying for Medicaid or AHCCCS is suggested and may be required if it appears you may qualify for either of those.