1515 Main Street
Highland, IL 62249
(618) 651-2600

Reserved for hospital use

Dear Patient,

St. Joseph's Hospital of Highland strives to provide quality health care to meet the needs of all people in the community it serves, regardless of their ability to pay. St. Joseph's Hospital of Highland provides all uninsured patients with a discount.

Please indicate your family size and household income on the back of this form, sign the form, and mail to:

St. Joseph's Hospital
Customer Service Department
1515 Main Street
Highland, IL 62249

Please return within 5 days of your visit. This information will be used to calculate and apply your discount. The discount will be reflected on the guarantor statement following receipt of the form. You will also be notified if you may qualify for additional financial assistance.

If you have any questions regarding this letter or if you have insurance, please contact our Customer Service department Monday thru Friday 8:00 AM - 4:00PM. If the patient's last name begins with A-J, please call (618) 651-2551. If the patient's last name begins with K-Z, please call (618) 651-2552.

Sincerely,

Julie A. LaFrance
Director, Patient Financial Services

(over)

St Joseph's Hospital
of Highland

1515 Main Street
Highland, IL 62249
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Family Size (**)	Household Annual Income (**)	
___________	**Income:** (from line 22 of federal Form 1040 or line 4 of federal form 1040EZ)	$ ___________
	Non-taxable income: **IRA distributions:** (from line 15a of federal Form1040)	$ ___________
	Pensions & Annuities: (from line 16a of federal Form 1040)	$ ___________
	Social Security benefits: (from line 20a of federal Form 1040 or from Social Security Benefit Statement)	$ ___________
	Total Household Annual income	$ ___________

Are you self-employed? (circle) YES NO

** Include all persons and income listed on the patient's tax return and any tax return the patient is claimed on.

I do not currently have health insurance through an employer or governmental program.

I hereby confirm that the above information is correct. I will notify the hospital of any changes in my income or insurance within six months of this signature.

_______________________________ ______________

Guarantor Signature **Date**

Return the completed and signed form to:

St. Joseph's Hospital
Customer Service Department
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Highland, IL 62249