



111 Spring Street  
Streator, IL 61364-3399  
(815) 673-2311

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date of Service

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

Please take a moment to complete the information requested below. The answers will help PFS staff know if you may qualify for any medical assistance programs offered through the state or Christian Care assistance through the hospital.

	Yes	No
Are you a full-time Illinois Resident?	_____	_____
Do you have children (18 or younger) living in your home?	_____	_____
Are you or your spouse pregnant?	_____	_____
Do you receive social security income or social security disability?	_____	_____
Does your doctor consider you disabled to work?	_____	_____
If yes, how long have you or will you, be unable to work?	_____	_____
How many family members live in your home (number claimed on your income taxes)	_____	
What is your estimated monthly gross household income? (Hourly wage and average number of hours worked per week)	_____	
Balance of other outstanding medical expenses that you owe	_____	