

Community Care Program Eligibility Application

Applicant: _____ Age: _____ Spouse: _____ Age: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Time at Present Address: _____ Phone: _____ # in Family _____

Applicant

Spouse

Employment Status: Full-time Part-time Lay off Full-time Part-time Lay off
 Temporary leave Unemployed Temporary leave Unemployed

Last/Current Employer: _____

Business Address: _____

Business Phone: _____

Occupation: _____

Start of Employment _____ Last Date of Employment _____ Start of Employment _____ Last Date of Employment _____

Social Security No.: _____

Dependents (list each by name):

_____ Age: _____ _____ Age: _____ _____ Age: _____
 _____ Age: _____ _____ Age: _____ _____ Age: _____

Did you file Taxes last year? _____ (if yes, you must include a complete copy of your taxes)

INCOME (Applicant and Spouse)

Total household income from all sources before taxes ~ PROOF OF INCOME IS REQUIRED.

SOURCE(S) OF INCOME (Check all that apply and include the Annual Amount)

Annual Amount:

<input type="checkbox"/> Wages _____	\$ _____
<input type="checkbox"/> Social Security _____	\$ _____
<input type="checkbox"/> Unemployment _____	\$ _____
<input type="checkbox"/> Pension Income _____	\$ _____
<input type="checkbox"/> Tax Refund _____	\$ _____
<input type="checkbox"/> Alimony/Child Support _____	\$ _____
<input type="checkbox"/> Other _____	\$ _____

Attach proof of income – Last two check stubs for all Sources of Income listed above.

ASSETS - SAVINGS (Applicant & Spouse combined)

<u>Type</u>	<u>Financial Institution</u>	<u>Phone #</u>	<u>Account #</u>	<u>Amount</u>
Checking: _____	_____	_____	_____	\$ _____
Savings: _____	_____	_____	_____	\$ _____
Other: _____	_____	_____	_____	\$ _____

Please include last 3 months of Bank Statements

ASSETS - AUTO OR TRUCK

Make & Year: _____ Est. Value: \$ _____ Loan Balance: \$ _____
 Make & Year: _____ Est. Value: \$ _____ Loan Balance: \$ _____

Lending Institution(s): _____

<p>for office use only: Guarantor Number: _____ Guarantor Name: _____</p>
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(continued)

Community Care Program Eligibility Application (continued)

Memorial Health Center
135 South Gibson Street Medford, WI 54451

ASSETS - PROPERTY:

Home – Location: _____
Fair Market Value: \$ _____ Mortgage Balance: \$ _____
Lending Institution: _____
Other Property – Location: _____
Fair Market Value: \$ _____ Mortgage Balance: \$ _____
Lending Institution: _____

Include copy of property taxes for each property owned.

OTHER ASSETS (Boats, ATVs, Motorcycles, Snowmobiles, etc.)

<u>Description</u>	<u>Estimated Value</u>	<u>Loan Balance</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

REGULAR MONTHLY PAYMENTS

Estimated Monthly Payments

Rent or Mortgage Payment: \$ _____	Utilities: _____
Alimony or Child Support: \$ _____	Insurance: _____
Auto Loan Payments: \$ _____	Phone: _____
Other Loan Payments: \$ _____	Credit Cards: _____

Please include a few comments that explain your current financial situation and why you are applying for Community Care:

I attest that the above information is accurate to the best of my knowledge and truly represents my current financial status.
I authorize Memorial Health Center to verify any information given on this financial statement, and to run a credit report if necessary to process this application.

Signature of Patient or Responsible Party Date

(For Patient Financial Services Use)

Determination of Eligibility

Applicant is: Eligible _____ Ineligible _____
Total Income: \$ _____ Members in Family _____ % of Com Care Award _____
Total Amount of Hospital Bill: \$ _____ Community Care Allowance: \$ _____
Total Amount of Clinic Bill: \$ _____ Patient's Responsibility: \$ _____
Patient Representative's Signature: _____ Date: _____
VP-Finance Signature: _____ Date: _____

Notes: _____

(10/03; 5/04; 3/06; 3/07; 10/07)