Patient Name: _____

Medical Record Number: _____

Guarantor: _____

GUNDERSEN
ST. JOSEPH'S
HOSPITAL AND CLINICS

COMMUNITY CARE APPLICATION

Referred by: _____ Today's Date: _____ Date Due: _____

Last Name: _____ First Name: _____

CHECKLIST

☐ Did you file taxes: ☐ No ☐ Yes
If yes, send a complete copy of your Federal Tax Returns including all schedules. To request a copy of your taxes, please call 1-800-829-1040. A copy of your W2 is not needed.

☐ Pay Stub(s) or other written form of income verification for last 30 days.

☐ Apply for Medical Assistance through your county for everyone in your household and submit a copy of **all pages** of the Medical Assistance Determination. This is required for every uninsured person that applies for financial assistance. For additional information on how to apply for Medical assistance, please contact a representative (in the state in which you reside):
Wisconsin: 1-800-362-3002 Minnesota: 1-800-657-3739 Iowa: 1-800-972-2017

☐ Submit a letter explaining your current financial situation. If you have no income or if your expenses exceed your income – please explain how you are supporting yourself.

☐ Copy of mortgage balance statement for all properties owned and property tax bills.

☐ Copy of other verifications, such as bank statements, 401K balance statements, etc. If you are self-employed, please send a copy of your business account bank statements for 60 days.

☐ If you are unable to work due to medical conditions and have not already been approved for Social Security Disability Income, please provide written verification that you have applied for SSDI and the current status. For help applying, please contact the Social Security office directly at 800-772-1213 or call the Aging and Disability Resource Center in your area. You can also apply online at www.socialsecurity.gov

☐ Signed and completed Financial Assistance Application.

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

Applicant:

Name _____ Date of Birth _____
Last First MI

Spouse _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code County

Phone # (____) _____ Social Security # _____

Phone # (____) _____ Social Security # _____

(If married or separated, spouse information and signature is required)

☐ married ☐ single ☐ widowed ☐ divorced ☐ separated

List of dependants living with you:

Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

Patient Name: _____

Medical Record Number: _____

Guarantor: _____

GUNDERSEN
ST. JOSEPH'S
HOSPITAL AND CLINICS

COMMUNITY CARE APPLICATION

Employment Information of Applicants

Primary Applicant

Employer: _____
City/State: _____
Phone: _____
Hire Date: _____
Occupation: _____
Gross Monthly Salary: _____

Spouse

Employer: _____
City/State: _____
Phone: _____
Hire Date: _____
Occupation: _____
Gross Monthly Salary: _____

Primary Applicants Additional Source of Income		Secondary Applicant Additional Source of Income	
Interest, Dividends	$	Interest, Dividends	$
Rental Income	$	Rental Income	$
Food Stamps	$	Food Stamps	$
Alimony/Child Support	$	Alimony/Child Support	$
Pension	$	Pension	$
Worker's Compensation	$	Worker's Compensation	$
Unemployment	$	Unemployment	$
Farm/Self Employment Inc.	$	Farm/Self Employment Inc.	$
SSI/Social Security	$	SSI/Social Security	$
Veterans Benefits	$	Veterans Benefits	$
Other Wages	$	Other Wages	$

If you list additional income above, please provide written verification of that income for the past 30 days.

Property

Residence: ☐ Rent $ _____ ☐ If no mortgage or rent please explain why: _____
☐ Own

	Monthly Payments	Estimates Value	Unpaid Balance
1st Mortgage	$	$	$
2nd Mortgage	$	$	$
Other Real Estate	$	$	$

Vehicles – Make/Type/Year

Auto #1 _____	$	$	$
Auto #2 _____	$	$	$
Recreational _____	$	$	$

Assets

Checking Balance…… $ _____
Stocks…… $ _____
Bonds…… $ _____
IRA…… $ _____

Savings Balance…….. $ _____
CD…….. $ _____
401K…….. $ _____
Other Assets…… $ _____

I certify that the preceding Income/Expense information is true and correct. Please be aware we may review the information you have provided in conjunction with your credit report for verification of debts listed.

_____ (Signature – Applicant)

_____ (Signature – Spouse)

_____ Date

_____ Date