

# West Bend Clinic

Froedtert & Community Health

You have expressed an interest in applying for a Community Care grant.

Please fill out the following application and provide the additional information requested below. We cannot process your application without this information. If you do not have the information requested, indicate the reason. Any prior applications are no longer valid and Credit Bureau reports are routinely requested to verify ability to pay medical bills.

## **Additional information needed:**

- Photocopy of your last 3 months checking and savings accounts.
- Photocopy of your last Federal Income tax return including all attachments.
- Photocopy of all adult members' last W-2 forms.
- Photocopy of the last paycheck stub from employers of each adult working member of your family.
- Photocopy of Real Estate Property Tax bills for **all** real estate owned.
- Photocopy of the denial letter from County Social Services Department (306-2282).

Please contact West Bend Clinic's Financial Services Department at 262-306-6278 with any questions or concerns regarding this application or the Community Care program.

Thank you for continuing to work with us so we can help meet your needs.

## West Bend Clinic, Inc . Application for Community Care

To our patients: The purpose of this form is to provide basic financial information to assist us in determining the most appropriate method and level of payment for the services you received here.

To be eligible for consideration, this form MUST be returned by: \_\_\_\_\_.

Attach copy of denial for alternative funding from lending institution for balances over \$\_\_\_\_\_.

Name: \_\_\_\_\_

Last First Middle Initial

Address: \_\_\_\_\_

Street/Apt # City State Zip Code

How long at address above: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Marital Status: Married Never Married Widowed

Divorced Separated

Patient Social Security #: \_\_\_\_\_ Are you a U. S. citizen? Yes No

Spouse Social Security #: \_\_\_\_\_ Are you a U. S. citizen? Yes No

Patient's Employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_

Street City State Zip Code

Spouse Name: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_

Street City State Zip Code

If patient is a minor, please provide the following information:

Mother's Name: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Name of Patient's Dependents	Birth Date		Name of Patient's Dependents	Birth Date

# Income Information

**Sources of Income Include:** public assistance payments, social security, unemployment or worker's compensation benefits, child support, foster care benefits, alimony/maintenance, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust refunds, compensation for injury claims.

<b>Monthly Income:</b>	<b>Patient or Mother</b>	<b>Spouse or Father</b>
Earnings (Gross)	\$	\$
Spouse's Earnings (Gross)	\$	\$
Social Security	\$	\$
Spouse's Social Security	\$	\$
Pension	\$	\$
Spouse's Pension	\$	\$
Unemployment	\$	\$
Public Assistance	\$	\$
Interest Dividends	\$	\$
Rental Income	\$	\$
Veterans Benefits	\$	\$
Worker's Compensation	\$	\$
Maintenance/Support	\$	\$
Foster Care	\$	\$
Disability	\$	\$
Other	\$	\$
<b>TOTAL MONTHLY INCOME:</b>	\$	\$
(A) Total Monthly Income X 12	\$	
		\$
<b>Yearly Income:</b>		\$
Interest per year on Savings	\$	
Income from Dividends and Interest (stocks, bonds, etc)	\$	
Income from Estates, Trusts, Other	\$	\$
<b>(B) TOTAL YEARLY INCOME:</b>	\$	
<b>TOTAL ANNUAL INCOME (A+B)</b>	\$	\$

(12 X Total Monthly Expenses)

# Asset Information

	Location	Amount/Value
Checking		\$
Savings		\$
Certificate of Deposit		\$
Stocks/bonds		\$

Auto/Truck/Recreational Vehicles

Type	Make & Year	Estimated Value	Loan Balance	Equity (Value-Balance)	Monthly Payment
Vehicle #1		\$	\$	\$	
Vehicle #2		\$	\$	\$	
Snowmobile		\$	\$	\$	
Boat/Motor		\$	\$	\$	
Motorcycle		\$	\$	\$	
ATV		\$	\$	\$	
Motorhome		\$	\$	\$	
Other		\$	\$	\$	
<b>TOTAL</b>		\$	\$	\$	

## Liability/Expense Information

Monthly Expenses:				
Rent or Mortgage Pymt	\$			
Utilities: Phone	\$			
Utilities: Heat	\$			
Utilities: Electric	\$			
Child Care	\$			
Child Support	\$			
Food	\$			
Property Taxes	\$			
State, Federal, FICA	\$			
Insurance (car, home, etc)	\$			
Loans (total monthly pymts)	\$			
Other (medication, nursing home care for spouse, etc)	\$			
Other monthly expenses:		To Whom Owed	Address	Amount Owed
	\$			\$
	\$			\$
	\$			\$
<b>Total Monthly Expenses:</b>	\$			
<b>TOTAL ANNUAL EXPENSES:</b>				

Homestead Real Estate: \_\_\_\_\_

Landlord or Mortgage Holder Amount Owed Monthly Payment

\_\_\_\_\_ - \_\_\_\_\_ = \_\_\_\_\_

Fair Market Value Amount Owed Equity

Other Real Estate: \_\_\_\_\_

Landlord or Mortgage Holder Amount Owed Monthly Payment

\_\_\_\_\_ - \_\_\_\_\_ = \_\_\_\_\_

Fair Market Value Amount Owed Equity

Insurance Coverage: List all health insurance policies or plans which provide full or partial coverage to you, including Medicare Part A and Part B.

Have you ever gone through bankruptcy or had any judgment or legal action against you?

Applicant/Spouse: No / Yes, please explain

Other Considerations:

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Briefly describe the reason you are applying for Community Care including details of medical needs and/or financial concerns

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Please attach a verification of income such as the most recent copy of your federal tax form, payroll, unemployment, social security and your last three bank statements. Credit Bureau reports are routinely requested to assist in determining ability to pay medical bills.

If you have listed no source of income, please explain how you have been supporting yourself. Or, if your income is insufficient to support yourself and you rely on the financial support of someone for your housing, food, etc, that person must complete the "Letter of Attestation" stating they provide financial support for you. The completed letter should be attached and returned with the Application.

Based upon the above statement of facts, I submit this application for "Community Care" consideration for medical services incurred at the West Bend Clinic, Inc. As such, I make this statement true and complete to the best of my knowledge. I authorize the clinic to verify or obtain additional information concerning my credit status. I also agree to notify you of any changes that may occur in this information.

This statement becomes the property of West Bend Clinic, Inc.

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Signature Date

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Spouse Signature Date

**\*\*FOR OFFICE USE ONLY\*\***

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Approved by Date Denied by Date