REEDSBURG AREA MEDICAL CENTER

2000 North Dewey Avenue, Reedsburg, WI 53959 • 608-524-6487

Community Care Application

Please complete and return by:_____

Name: _____ Soc. Sec.#: _____

Address: _____ Phone: _____

Employer/Phone: _____

Occupation: _____

Insurance: _____ Birthdate: _____

Spouse: _____ Soc. Sec.#: _____

Address: _____ Phone: _____

Employer/Phone: _____

Occupation: _____

Insurance: _____ Birthdate: _____

Dependents (name and relationship):

_____ age: _____ _____ age: _____

_____ age: _____ _____ age: _____

_____ age: _____ _____ age: _____

_____ age: _____ _____ age: _____

Are you a student? (circle one) Yes No Full or Part-time

Are you a U.S. citizen? (circle one) Yes No

MONTHLY INCOME (GROSS)*

Employment/wages: _____

Unemployment Compensation: _____

Disability Compensation: _____

Pension or Retirement: _____

Social Security: _____

Child Support: _____

Welfare Payments/AFDC: _____

TOTAL MONTHLY INCOME: _____

*__Note__: Proof of income in the form of your most recent **Federal Income Tax Return** and your most recent **paycheck stub(s)** must be returned with this application. If applicable, a **bank statement** which reflects direct deposits for social security or Veterans disability payments is also needed. If you haven't filed taxes in the prior 2 years, write in, "No taxes filed since (indicate year)"

Specify any reasons for anticipated change (increase or decrease) in present income: _____

_____

If you have no source of income, please explain in detail how you support yourself: _____

_____

_____

ASSETS (INCLUDING SPOUSE)

(Name of Bank) *(Balance)*

Checking: _____

Savings: _____

CD's, IRA's, 401K: _____

Property (indicate type, location, assessed market value, balance owed): _____

_____

_____

_____

Vehicles (cars, trucks, campers, motorhomes, boats, ATV, snowmobiles, motorcycles, dirtbikes, etc):

Type	*Model/Year*	*Approx Value*	*Amount Owed*

MONTHLY EXPENSES*

Mortgage/Rent (circle one): _____

Second Mortgage: _____

Food: _____

Utilities (heat, electric, water, phone, cable: _____

Vehicle Expense (gas, repairs, loan, etc): _____

Child Care: _____

Alimony/Child Support: _____

Credit Cards:

Name	*Monthly Payment*	*Balance Due*

Health Insurance Premium: _____

Medical Bills (Medication, clinic, hospital, dental, etc. List only what you pay out of pocket):

_____

_____

_____

Other Expenses: _____

_____

TOTAL MONTHLY EXPENSES: _____

*__Note__: All outstanding debt with a balance of $2,000 or more must be verified in writing. Examples would include a statement from the debt holder or a copy of most recent billing.

Please indicate any additional information that may have a bearing on this application.
Use the back of this form if more space is needed.

_____

_____

_____

_____

_____

_____

_____

_____

NOTICE TO APPLICANT: This program is for the benefit of our community. Therefore, area residents that are U.S. citizens have priority in application consideration. In order to be considered for Community Care, all other sources of payment must be exhausted (i.e. third party liability, insurance, or forms of Medical Assistance). Any account pending liability determination by a third party payor will be excluded from consideration until such determination is made.

This information provided to Reedsburg Area Medical Center is regarded as confidential and will be used only to determine income verification for services provided by this facility. I AFFIRM that the information provided is true and accurate to the best of my knowledge; and I AUTHORIZE Reedsburg Area Medical Center to verify any information given on this application in the determination of my eligibility for financial assistance. I understand that failure to comply with verification requirements within 10 working days of this application date will result in denial of my application. I also understand that if the information I submit is determined to be false, the result will be a denial of my application, and I will be responsible for payment of the services provided.

x _____ Date: _____

Patient/Responsible party