Financial Disclosure
Application for Community Care

1515 Park Avenue - Columbus, WI 53925 - Phone 920-623-2200 · Fax 920-623-1518

Name____________________ Soc. Sec. #________________ Birth Date________________

Address____________________________ Phone________________

City____________________ State________________ Zip________________

Employer____________________( )________ Occupation________________
(Complete business name and telephone number)

Insurance____________________ Identification #________________ Effective Date________________

Spouse____________________ Soc. Sec. #________________ Birth Date________________

Employer____________________( )________ Occupation________________
(Complete business name and telephone number)

Insurance____________________ Identification #________________ Effective Date________________

Dependents (name and relationship)

____________________ Age________ ____________________ Age________

____________________ Age________ ____________________ Age________

FAMILY INCOME: Represents total cash receipts for all sources before taxes including, but not limited to, wages, public assistance payments, social security, unemployment or worker's compensation benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust incomes, tax refunds, compensation for injury claims. Income is to be stated on a gross earnings/receipts basis. **Family income includes all income for immediate family members residing in the same household**.

SOURCE OF INCOME – Patient	Monthly Amount	Spouse/Other Family	Monthly Amount

Payroll Deductions: $____________________________
(i.e., Union dues, insurance premiums, garnishments, pre-tax, etc.)

ASSETS – PROPERTY:

Homestead: Location____________________________

Assessed taxable value: $________________ Mortgage due: $________________

Other Property: Location____________________________

Assessed taxable value: $________________ Mortgage due: $________________

ASSETS – SAVINGS (PATIENT AND SPOUSE COMBINED)					
Type	**Financial Institution**	**Address**	**Phone #**	**Account #**	**Balance**
Checking					
Savings					
CD's/IRA's					

ASSETS – AUTO OR TRUCKS		
Make, Model and Year:	Mileage:	Loan Balance: $
Make, Model and Year:	Mileage:	Loan Balance: $

OTHER ASSETS – RECREATIONAL VEHICLES

Type	Estimated Value	Loan Balance	Type	Estimated Value	Loan Balance
Snowmobile			3-Wheeler/Quad		
Boat/Motor			Motor home		
Motorcycle			Other RV		

REGULAR MONTHLY EXPENSES STATED ON A MINIMUM MONTHLY PAYMENT BASIS

	Payment		Balance	Payment
Rent		Other Loan		
Mortgage Payment		Medical Debt (specify)		
2nd Mortgage		Medical Debt (specify		
Alimony/Child Support		Medical Debt (specify)		
Insurance Premiums		Credit Card (specify)		
Continuous Medication		Credit Card (specify)		
Food		Other (specify)		
Utilities		Other (specify)		
Transportation-Gas		Other (specify)		

I hereby submit the above statement for the purpose of allowing Columbus Community Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs, and do hereby authorize Columbus Community Hospital to verify this information as necessary, which may include obtaining a credit bureau report, employment or income verification, and appropriate supporting documentation.

I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should, at any time, any of this information prove to be false, all Community Care grants will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

By applying for Community Care, I also agree to accept payment responsibility for any amount due from me as a result of any grant which may be awarded.

______________________________ ______________
Applicant **Date**

______________________________ ______________
Spouse/Family Member **Date**

Note: Proof of current income must be provided at the time of application, plus copies of your most recently filed Federal Income Tax Return. All outstanding debt with a balance of $2,000 or more must be verified in writing. (Examples would include a statement from debt holder or copy of most recent billing.)

HAVE YOU INCLUDED : ☐ **Signed Application** ☐ **Federal Tax Return** ☐ **Paycheck Stub**