

## COMMUNITY CARE AND FINANCIAL ASSISTANCE APPLICATION

Completing form:				Date completed:						
Patient name:				Social Sec	curity #	Birth date:				
GUARANTOR: R	Rel.to Patient:			SPOUSE:		Rel.to Patient:				
Address:				Address:						
	ounty: Home Phone:				County: Home Phone:					
Employer: E	mployer: Empl.Date:			Employe	mployer: Empl.Date:					
Employer Address:				Employer Address:						
Employer Phone:				Employer Phone:						
If unemployed, last day/mo & yr worked:				If unemployed, last day/mo & yr worked:						
Marital Status (check one	e): ☐Married	I □ Si	ngle	□ Separ	ated 🗆 Di	vorced	□ Widowe	ed		
Monthly income received	by guarantor (a	and spouse	e, if appli	cable)						
Monthly Income: Gross: Net:				Monthly Income: Gross: Net:						
☐ Full Time ☐ Part Time Hourly Wage				$\square$ Full Time $\square$ Part Time Hourly Wage $\_$						
Job Title:				_ Job Title:						
Monthly Soc. Sec. Income:				Monthly Soc. Sec. Income:						
□SS Disability □SSI □SS Retirement □ SS Survivor Benefit				· · · · · · · · · · · · · · · · · · ·						
SSDI Applied For: Date:				SSDI Applied For: Date:						
Pension: Rental Income:										
Unemployment: Cert of Dep./IRA:				Unemployment: Cert of Dep./IRA:						
				_ 401k: Other:						
Checking Acct. Avg. Mo. B										
Name of Bank:										
Savings Acct. Balance				_						
Name of Bank				Name of	Bank					
DEPENDENTS		Age	Joint Custody (Y/N)	Does Child Live With You?  (Y/N) How Much		Is Other Parent on MA? (Y/N)	Monthly Support	Paid? Rcvd?		

Assets						
Automobile make/model:	Own/lease:	Year:	Balance owed:			
Automobile make/model:	Own/lease:	Year:	Balance owed:			
Real Estate value:	Balance on Mor	tgage:				
Did you file taxes last year? ☐ Yes (P		attach copy)	☐ No, Reason:			
Monthly Household Expenses						
Rent:	Cable TV:		Food:			
Mortgage:						
Real Estate Taxes:						
Heat:						
			Other (tax deferred contributions):			
Water/sewer:						
				enter's □Life □Health		
Remarks:			,			
Household/Family Medical and Other Bi Hospital/Doctor/Clinic (List Names):  1. 2. 3. 4.	Bala	nce:	Monthly			
Bank Loans/Credit Cards/or Other Bills  1.	(List Names): Bala			Payment:		
<u>2</u> . <u>3</u> . 4.						
·	additional expenses, ple	ase attach a s	eparate sheet)			
I understand this information will be used or Healthcare and will be kept confidential. My this form. To the best of my knowledge, the information	signature authorizes Sa	auk Prairie Hea				
	i provided above is true	and correct.				
Patient/Guarantor Signature:				Date:		
Signature of person completing form if differ	ent from patient:			Date:		
For evaluation with the Community Care Pro  Completed Financial Statement  Last year's Federal Taxes includi  Current pay stubs / unemployme  * if you are currently not employ meet your daily living expenses. include either a copy of your ben your bank statement showing the Copy of checking & savings acco  Mortgage statement showing ba Home equity statement showing	(both pages filled out ng all tax schedules (is ent statements ed or have not filed tax of the first statement from edirect deposit.  If you receive Social Statement from edirect deposit.  In the statement lance due, if a homeo	entirely and s if applicable) exes, submit a Security incon the Social Security	igned) signed letter explair ne due to age or disa	bility, please		

 $\hfill\Box$  Form completed with patient via phone