



# CHARITY CARE APPLICATION

www/stjoeschipfalls.org

Please complete both sides of this form, sign and date it.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Patient)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Guarantor/Responsible Party)

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Guarantor)Responsible Party)

Telephone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Dependent Children: \_\_\_\_\_

## MONTHLY INCOME

Patient's Employer: \_\_\_\_\_ Self-employed

Spouse/Parent Employer: \_\_\_\_\_ Self-employed

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

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

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

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

City: \_\_\_\_\_

City: \_\_\_\_\_

How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_

How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_

Unemployed  How long? \_\_\_\_\_

Unemployed  How long? \_\_\_\_\_

Social Security ..... \$ \_\_\_\_\_

Social Security ..... \$ \_\_\_\_\_

Unemployment Comp. .... \$ \_\_\_\_\_

Unemployment Comp. .... \$ \_\_\_\_\_

Worker's Comp. .... \$ \_\_\_\_\_

Worker's Comp. .... \$ \_\_\_\_\_

Child Support/Alimony ..... \$ \_\_\_\_\_

Child Support/Alimony ..... \$ \_\_\_\_\_

Public Assistance/Housing/Food Stamps ... \$ \_\_\_\_\_

Public Assistance/Housing/Food Stamps ... \$ \_\_\_\_\_

Grants ..... \$ \_\_\_\_\_

Grants ..... \$ \_\_\_\_\_

Pension ..... \$ \_\_\_\_\_

Pension ..... \$ \_\_\_\_\_

Rental Income ..... \$ \_\_\_\_\_

Rental Income ..... \$ \_\_\_\_\_

Investment Interest ..... \$ \_\_\_\_\_

Investment Interest ..... \$ \_\_\_\_\_

Source: \_\_\_\_\_

Source: \_\_\_\_\_

Other Income ..... \$ \_\_\_\_\_

Other Income ..... \$ \_\_\_\_\_

Source: \_\_\_\_\_

Source: \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

Do any other persons contribute financially to the family:  Yes  No If yes, amount \$ \_\_\_\_\_ Describe: \_\_\_\_\_

## ASSETS

Savings \$ \_\_\_\_\_

Cash on Hand \$ \_\_\_\_\_

Institution: \_\_\_\_\_

Stocks or Bonds \$ \_\_\_\_\_

Checking \$ \_\_\_\_\_

Money Market or CD \$ \_\_\_\_\_

Institution: \_\_\_\_\_

IRA or 401K \$ \_\_\_\_\_

Other Assets: \_\_\_\_\_

Primary Residence \$ \_\_\_\_\_

Property (Land, Secondary Residence \$ \_\_\_\_\_

PLEASE COMPLETE BACK OF PAGE

**DEBTS / EXPENSES**

Liabilities	To Whom	Monthly Payment	Balance	OTHER EXPENSES (including Medical):
Mortgage/Rent	_____	_____	_____	_____
Real Estate Properties	_____	_____	_____	_____
Bank Loan	_____	_____	_____	_____
Auto Loan	_____	_____	_____	_____
Credit Cards:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

PLEASE USE THIS SPACE TO DESCRIBE YOUR PERSONAL SITUATION AND YOUR REASONS FOR REQUESTING ASSISTANCE.

**The following documents must be provided for patient and guarantor.**

Federal Income Tax Return  Yes  No If no please explain: \_\_\_\_\_  
 \_\_\_\_\_

Proof of Public Assistance (Food Stamps, Housing Assistance)  Yes  If no please explain: \_\_\_\_\_

Current Bank Statement  Yes  No If no please explain: \_\_\_\_\_  
 (Past 90 Days) \_\_\_\_\_

Account Statements for CD, Money Market, 401K, IRA, Stocks, Bonds  Yes  If no please explain: \_\_\_\_\_

Current Pay Check Stub (s)  Yes  No If no please explain: \_\_\_\_\_  
 (Past 90 Days) \_\_\_\_\_

Statement of income from other sources (Social Security, Pension, Grants, Worker's Compensation)  Yes  No

This is to advise that I have pursued all other avenues possible for payment, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations; therefore, I hereby request St. Joseph's Hospital make a determination of my eligibility for their Charity Care Program. I understand that the information I submit concerning my income, family size, assets, expenses, and medical bills is subject to verification by St. Joseph's Hospital. I also understand that if the information I submit is now or at any time in the future determined to be false, such a determination will result in current and/or retroactive denial of Charity Care and I will be liable for charges for services rendered. I certify that all of the information in this form is true and correct. Incomplete or fraudulent application will be denied.

\_\_\_\_\_  
 Patient or Responsible Party Signature Date

Return Application to: Patient Financial Services, St. Joseph's Hospital, 2661 County Highway I, Chippewa Falls, WI 54729  
 Phone No.: (715) 726-3477