



St. Joseph's

HOSPITAL
CHIPPEWA FALLS, WISCONSIN

AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

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 \$ _____

Institution: _____

Checking \$ _____

Institution: _____

Other Assets: _____

Cash on Hand \$ _____

Stocks or Bonds \$ _____

Money Market or CD \$ _____

IRA or 401K \$ _____

Primary Residence \$ _____

Property (Land, Secondary Residence \$ _____

DEBTS / EXPENSES

Liabilities	To Whom	Monthly Payment	Balance	OTHER EXPENSES (including Medical):
Owing				
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) 717-7477