



CHARITY CARE APPLICATION

St. Joseph's Hospital offers financial assistance to those patients who request help and qualify. Guidelines have been established to ensure that the Hospital's limited charity care resources are used to treat patients who qualify and are not used by those unwilling to pay or have alternate pay sources. The patient and/or responsible party will be notified of the Charity Care Committee's decision by telephone and/or a written confirmation within 90 days upon receipt of all requested information.

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.

Patient or Responsible Party Signature

Date

CONFIDENTIAL FINANCIAL STATEMENT

Name: _____
(Patient)

Birth Date: _____ Social Security Number: _____
(Month/Day/Year)

Name: _____
(Responsible Party)

Birth Date: _____ Social Security Number: _____
(Month/Day/Year)

Street Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____ Marital Status: _____

Name of Health Insurance or Group Plan: _____

HOUSEHOLD SIZE

Listed below are my dependents:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MONTHLY HOUSEHOLD INCOME

Patient/Responsible Party

Employer Name: _____

Address: _____

City: _____

How Long _____ to _____ Wages \$ _____
(month/year) (month/year)

Social Security - - - - - \$ _____

Unemployment Comp - - - - - \$ _____

Alimony - - - - - \$ _____

Support Payments - - - - - \$ _____

Housing Allowance - - - - - \$ _____

Pension - - - - - \$ _____

Source: _____

Rental Income - - - - - \$ _____

Source: _____

Interest - - - - - \$ _____

Source: _____

Other Income - - - - - \$ _____

Source: _____

TOTAL \$ _____

Spouse/Significant Other

Employer Name: _____

Address: _____

City: _____

How Long _____ to _____ Wages \$ _____
(month/year) (month/year)

Social Security - - - - - \$ _____

Unemployment Comp - - - - - \$ _____

Alimony - - - - - \$ _____

Support Payments - - - - - \$ _____

Housing Allowance - - - - - \$ _____

Pension - - - - - \$ _____

Source: _____

Rental Income - - - - - \$ _____

Source: _____

Interest - - - - - \$ _____

Source: _____

Other Income - - - - - \$ _____

Source: _____

TOTAL \$ _____

ASSETS

Savings: \$ _____

Institution: _____

Checking: \$ _____

Institution: _____

Cash on Hand: \$ _____

Stocks or Bonds: \$ _____

IRA or CD Account: \$ _____

Motor Vehicles

Make: _____

Year: _____

Make: _____

Year: _____

Other Assets: _____

Real Estate

Home Address: _____

Mortgage Holder: _____

Value: \$ _____

Monthly Payment: \$ _____

Balance: \$ _____

Other Real Estate Address: _____

Mortgage Holder: _____

Value: \$ _____

Monthly Payment: \$ _____

Balance: \$ _____

MONTHLY HOUSEHOLD EXPENSES

Patient/Responsible Party

Spouse/Significant Other

Mortgage/Rent ----- \$ _____	Mortgage/Rent ----- \$ _____
Property Taxes ----- \$ _____	Property Taxes ----- \$ _____
Income Taxes ----- \$ _____	Income Taxes ----- \$ _____
Utilities ----- \$ _____	Utilities ----- \$ _____
Car Payments ----- \$ _____	Car Payments ----- \$ _____

Credit Card Payments

Company Owed: _____	Amount Owed: _____	Monthly Payment: _____
Company Owed: _____	Amount Owed: _____	Monthly Payment: _____

Credit Card Payments

Company Owed: _____	Amount Owed: _____	Monthly Payment: _____
Company Owed: _____	Amount Owed: _____	Monthly Payment: _____

Installment Loans

Company Owed: _____	Amount Owed: _____	Monthly Payment: _____
Company Owed: _____	Amount Owed: _____	Monthly Payment: _____

Installment Loans

Company Owed: _____	Amount Owed: _____	Monthly Payment: _____
Company Owed: _____	Amount Owed: _____	Monthly Payment: _____

Transportation----- \$ _____	Transportation----- \$ _____
Food----- \$ _____	Food----- \$ _____

Insurance

Car Insurance: _____	Monthly Payment: _____
Home Insurance: _____	Monthly Payment: _____
Life Insurance: _____	Monthly Payment: _____
Medical Insurance: _____	Monthly Payment: _____

Insurance

Car Insurance: _____	Monthly Payment: _____
Home Insurance: _____	Monthly Payment: _____
Life Insurance: _____	Monthly Payment: _____
Medical Insurance: _____	Monthly Payment: _____

Child Care Expenses:

Child Support/Alimony ----- \$ _____	Child Support/ Alimony ----- \$ _____
Day Care----- \$ _____	Day Care----- \$ _____
Diapers/Formula ----- \$ _____	Diapers/Formula ----- \$ _____

TOTAL \$ _____

TOTAL \$ _____

OTHER DEBTS NOT LISTED ABOVE (Including Medical)

Company Owed	Total Amount	Monthly Payment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Income Tax Return Filed Yes No If no please explain: _____

Income Tax Return Attached Yes No If no please explain: _____

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

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

Please explain current situation that leads you to seek assistance from St. Joseph's Hospital: _____

Please return completed form to: Attn.: _____
 Credit Office
 St. Joseph's Hospital
 2661 County Highway I
 Chippewa Falls WI 54729

FOR CREDIT OFFICE USE ONLY

Total Amount Submitted for Consideration: _____ Meets Guidelines: Yes No

Comments: _____

Recommendation: FC _____ PC _____ DC _____ Review in _____ Days Initials: _____

Decision: FC _____ PC _____ DC _____ Review in _____ Days

Patient Notified: _____ Letter _____ Telephone Approval Initials: _____

Rev.: 08/02/2005 Date Approved: _____