

Sacred Heart Hospital Community Care Application

900 West Clairemont Avenue
Eau Claire, WI 54701
715-717-4141 or 888-445-4554

PATIENT NAME _____ ACCOUNT # _____

PATIENT

NAME	DATE OF BIRTH	MARITAL STATUS	SOCIAL SECURITY #
ADDRESS	HOW LONG AT THIS ADDRESS		HOME PHONE
EMPLOYER NAME AND ADDRESS, IF UNEMPLOYED – HOW LONG, IF SELF EMPLOYED EXPLAIN			EMPLOYER PHONE #
POSITION/TITLE	MONTHLY GROSS INCOME	MONTHLY NET INCOME	LENGTH OF CURRENT EMPLOYMENT

ADULTS OVER THE AGE OF 18 THAT ARE CLAIMED BY PARENTS AS A DEPENDENT ON THEIR PARENTS INCOME TAXES MUST INCLUDE PARENTS FINANCIAL INFORMATION.

SPOUSE/PARENT(S)/RESPONSIBLE PARTY

NAME	DATE OF BIRTH	SOCIAL SECURITY #	
EMPLOYER NAME AND ADDRESS, IF UNEMPLOYED – HOW LONG, IF SELF EMPLOYED EXPLAIN			EMPLOYER PHONE #
POSITION/TITLE	MONTHLY GROSS INCOME	MONTHLY NET INCOME	LENGTH OF CURRENT EMPLOYMENT

HOUSEHOLD INFORMATION

<p>NAME & YEAR OF BIRTH OF ALL PERSONS IN HOUSEHOLD (USE LINES PROVIDED BELOW)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>DO ANY OTHER PERSONS CONTRIBUTE FINANCIALLY TO THE FAMILY?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>IF YES, AMOUNT \$ _____</p> <p>DESCRIBE _____</p> <p>_____</p>
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MISCELLANEOUS INCOME PER MONTH

DIVIDENDS, INTEREST _____	CHILD SUPPORT/ALIMONY _____
PUBLIC ASSISTANCE/FOOD STAMPS _____	PENSIONS _____
SOCIAL SECURITY _____	INVESTMENT/RENTAL INCOME _____
UNEMPLOYMENT COMPENSATION _____	GRANTS _____
WORKERS COMPENSATION _____	OTHER (EXPLAIN _____)

CONTINUE ON BACK

SACRED HEART HOSPITAL COMMUNITY CARE APPLICATION (CONTINUED)

<u>ASSETS (OWN)</u>	<u>VALUE</u>
SAVINGS	\$ _____
CHECKING	\$ _____
IRA, CD'S, MONEY MARKET, ETC	\$ _____
HOME	\$ _____
SECONDARY RESIDENCE CABIN/VACATION HOME	\$ _____
PROPERTY ACRE(S) LOT(S)	\$ _____
BOAT, RECREATIONAL VEHICLES (ATV'S, MOTORCYCLES, CAMPERS, ETC.)	\$ _____
MOBILE HOME/MOTOR HOME MAKE MODEL YEAR	\$ _____
AUTO MAKE MODEL YEAR	\$ _____
OTHER ASSETS	\$ _____
	\$ _____
	\$ _____

<u>LIABILITIES (OWING)</u>	<u>TO WHOM</u>	<u>MONTHLY PAYMENT</u>	<u>BALANCE</u>
MORTGAGE/RENT	_____	_____	_____
REAL ESTATE PROPERTIES	_____	_____	_____
BANK LOAN	_____	_____	_____
AUTO LOAN	_____	_____	_____
CREDIT CARDS:			
ACCT#	_____	_____	_____
ACCT#	_____	_____	_____
ACCT#	_____	_____	_____
MONTHLY MEDICAL PAYMENTS (LIST)			
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
UTILITIES (LIST)			
	_____	_____	_____
	_____	_____	_____

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

INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY SACRED HEART HOSPITAL OR ITS AGENTS.

SIGNATURE

DATE

RELATIONSHIP IF OTHER THAN PATIENT