Patient Care Grant Request

Completed Community Care paperwork must accompany this application.

ROGERS MEMORIAL HOSPITAL
34700 Valley Road | Oconomowoc, WI 53066
(262) 646-4411 | (800) 767-4411

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR COMMUNITY CARE

I request that Rogers Memorial Hospital make a written determination of my eligibility for Community Care for uncompensated hospital services. I understand that the information that I submit concerning my annual income and family size is subject to verification by Rogers Memorial Hospital. I also understand that if the information that I submit is determined to be false, all granted Community Charity Care will be rescinded and I will be liable for any balance due.

Date: ______________________________

Name: ____________ ____________ ____________
First Middle Last

Address: ______________________ ________ ______ ________
Street Number City State Zip

Telephone Number: ____________ Social Security Number: ____________

Number of Years at Present Address: ____________

Family Size (including patient): ________ Spouse's Name: ____________

Family members (excluding patient):

Name	Age	Relationship

Hospital Insurance Information:

Name Of Insurance Company/Or Group Plan	Policy Number

Income: Please list Gross Monthly Income for all household members.

Return the following items for verification of income:
Tax Return and W-2 Statement, along with copies of check stubs for the last 90 days and, if own home, the property tax bill and mortgage statement. A determination cannot be made unless this is provided.

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Income:

	Patient/or Guarantor	Spouse/Guarantor
Employer		
Business Address		
City/State/Zip code		
Wage Rate	Hr/Wk/Mo/Salary	Hr/Wk/Mo/Salary
Business Phone		
Occupation		
How Long Employed		
Social Security Number		

Combined income for (Guarantors), you, spouse and other dependents:

	Total for Last 3 Months	Total for Last 12 Months
Wages	$	$
Farm or Self-employment		
Public Assistance		
Social Security		
Unemployment/Workman's Comp CC Compensation		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest		
Rent Income		
Others		
Total	$	$

Assets and Liabilities:

Assets: Patient, Spouse, and Other			Liabilities: Combined Bills & Debt of ALL Family Members		
Type	**Location**	**Amount**	**Type**	**Location**	**Amount**
Checking		$	Credit Union		$
Savings		$	Bank Loans		$
Credit Union		$	Credit		$
CD's		$	Other		$

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Assets – Property:

Home: ______________________________

Location: ______________________________

Assessed Taxable Value $ ______________ Mortgage Balance $______________

Other: ______________________________

Location: ______________________________

Assessed Taxable Value $ ______________________________

Assets – Auto or Truck:

1. Make and Year: ______________________________

Estimated Value $ ______________ Loan Balance $ ______________

2. Make and Year: ______________________________

Estimated Value $ ______________ Loan balance $ ______________

Other Assets: Life Insurance, Bonds, Stocks, Boats, Etc.

Description	Estimated Value	Loan Balance
	$	**$**
	$	**$**
	$	**$**

Regularly Monthly Expenses:

Rent	$	Alimony or Child Support	$
Mortgage Payment	$	Insurance Premiums	$
Auto Loan Payments	$	Utilities	$
Other Loan Payments	$	Other (Specify):	$

I affirm that the following information, including income, is true and correct to the best of my knowledge. Further, I hereby give my permission to Rogers Memorial Hospital to disclose any information contained above to any Federal, Local or State agency responsible for determining Rogers Memorial Hospital uncompensated service compliance.

I AUTHORIZE Rogers Memorial Hospital to verify any information given on this financial statement.

______________________________ ______________

Patient or Responsible Party Date