CHIPPEWA COUNTY WAR MEMORIAL HOSPITAL FINANCIAL ASSISTANCE FORM

PLEASE NOTE: IN ORDER TO REVIEW THIS REQUEST, YOU MUST COMPLETELY FILL OUT THIS FORM.

PLEASE PROVIDE A COPY OF YOUR MOST RECENT TAX RETURN OR PROOF OF NON-FILING

Patient Name: Social Security #:

Address: City: State/Zip:

Phone:

Employeer: Phone:

Address: City: State/Zip:

HOUSEHOLD SIZE:

SELF [ ]
SPOUSE [ ]
CHILDREN [ ]
OTHER _____ [ ]

TOTAL IN HOUSEHOLD _____

MONTHLY INCOME:

(PLEASE PROVIDE LAST YEARS TAX FORM AND PROOF OF CURRENT INCOME - PAY STUBS)

WAGES/EARNINGS $
SOCIAL SECURITY/DISABILTY $

TOTAL MONTHLY INCOME $

OTHER ASSETS:

[ ] BANK ACCOUNT(S) $
[ ] CASH $
[ ] VEHICLES $
[ ] INVESTMENTS $

TOTAL ASSETS: $

MONTHLY EXPENSES:

RENT/ MORTGAGE $
UTILITIES/PHONE, ETC. $
INSURANCE (HOME/AUTO) $
MEDICAL (BILLS/INSURANCE) $
LIVING EXPENSES (FOOD, CLOTHES) $
VEHICLE MAINTENANCE (GAS, OIL) $
CHILD SUPPORT/ALIMONY $
LOANS $
CREDIT CARD(S) $
TAXES $

TOTAL MONTHLY EXPENSES $

INSURANCE COVERAGE? [ ] YES [ ] NO

If NO have you applied for Medicaid or CHAC?

IF THERE ARE OTHER SPECIAL CIRCUMSTANCE(S) WHICH MAY ASSIST IN THE DECISION FOR ASSISTANCE, PLEASE USE THE SPACES BELOW TO EXPLAIN YOUR SITUATION. THANK YOU FOR YOUR TIME AND COOPERATION.
IF YOU NEED ADDITIONAL SPACE PLEASE CONTINUE ON A BLANK SHEET OF PAPER & ATTACH

I have read and understand the terms of this program. I have attached all necessary documents as my proof of need. I believe I may qualify for some level of financial assistance. I am requesting consideration for this assistance.

PATIENT /GUARANTOR DATE