



C/O Patient Financial Services Ext. 2085
 1400 East Side Road Platteville, WI 53818
 Phone 608-348-2331 Fax 608-342-4756

Community Care Application

Name _____ **Soc. Sec.#** _____ **Birth Date** _____

Address _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Employer (Name & Address) _____

Spouse _____ **Soc. Sec. #** _____ **Birth Date** _____

Employer (Name & Address) _____

Dependents **Name/Age** _____ **Name/Age** _____

Name/Age _____ **Name/Age** _____

Name/Age _____ **Name/Age** _____

Income: Represents total cash receipts for all sources before taxes included, but not limited to, wages, public assistance payments, social security, unemployment or worker's compensations benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust incomes, tax refunds, and compensation for injury claims.

Source of Income	Monthly Amount	Individual Receiving Income

Please make note of any financial changes, such as job loss, divorce, death, or any other hardship:

Have you or any family member ever applied for Medical Assistance? YES / NO When: _____

Reason for Denial: _____

Assets - Property / Homestead		
Location	Assessed Taxable Value	Mortgage Balance
Location	Assessed Taxable Value	Mortgage Balance
Location	Assessed Taxable Value	Mortgage Balance

Assets - Savings (Patient & Spouse)					
Type	Location	Amount	Type	Location	Amount
Checking			Credit Union		
Checking			CD's		
Savings			IRA's		
Savings			Other		

Assets - Auto or Truck		
Make & Year:	Estimated Value:	Loan Balance:
Make & Year:	Estimated Value:	Loan Balance:
Make & Year:	Estimated Value:	Loan Balance:

Other Assets - Recreational Vehicles		
Type (Boat/Motorcycle/Snowmobile/RV/etc)	Estimated Value	Loan Balance

Monthly Expenses (Please feel free to use the back of this page for additional space)			
	Payment Amount		Payment Amount
Rent		Alimony/Child Support	
Mortgage		Medications	
2nd Mortgage		Insurance Premiums	
Utilities		Transportation/Gas	
Cable/Satellite		Medical Bills (specify)	
Phone (include cell)		Credit Card (specify)	
Food		Other (specify)	

I attest that the information on this application is accurate to the best of my knowledge and truly represents my current financial status; and I authorize Southwest Health Center, Inc. to verify any information given on this application in the determination of my eligibility for Community Care.

Patient or Responsible Party Signature

Date

NOTE: THE FOLLOWING INFORMATION IS NEEDED WITH YOUR APPLICATION FOR PROCESSING

- 1. Written Denial for any State Medical Assistance Program (received through your County's Social Services Program)**
- 2. Income Verification (pay check stub, unemployment stub, bank statement, etc)**
- 3. Copy of most recently filed Federal Income Tax Returns**
- 4. Additional information as needed.**