MILE BLUFF MEDICAL CENTER, INC
FINANCIAL ASSISTANCE PROGRAMS APPLICATION

Completed application must be returned along with all supporting documentation within 30 days.

given by initials:________ date:________

1. Applicant's general information

last name______________________________________ first name______________________________________ MI______

birth date _____-_____-________ SS # ______-______-______ day phone # ______-______-__________

physical street address____

city____ state___________ zip ______________

mailing address (if different)____

check: _____employed FT _____employed PT ___unemployed ____retired _____disabled
*if applying for disability benefits, please provide a letter from your provider explaining your disability

employer____ phone # ______-______-__________

pay cycle? (circle one) weekly biweekly monthly

How long have you worked for this employer? ____________ currently hourly wage_______________

Is insurance available to you through your employer? yes no

Are you a student? no full time part time

2. Spouse / domestic partner's general information (if applicable)

last name______________________________________ first name______________________________________ MI______

birth date _____-_____-________ SS # ______-______-______ day phone # ______-______-__________

physical street address____

city____ state___________ zip ______________

mailing address (if different)____

check: _____employed FT _____employed PT ___unemployed ____retired _____disabled
*if applying for disability benefits, please provide a letter from your provider explaining your disability

employer____ phone # ______-______-__________

pay cycle? (circle one) weekly biweekly monthly

How long have you worked for this employer? ____________ current hourly wage________________

Is insurance available to you through your employer? yes no

Are you a student? no full time part time

3. Others living in the same household

name____ relationship___________________________ age______

name____ relationship___________________________ age______

name____ relationship___________________________ age______

name____ relationship___________________________ age______

4. Income information

Please list below the amount of **monthly gross income in your household from each category which applies.

wages ___________________ social security _________________ unemployment_________________

5. Assets informa (Only for applicants above 200% of poverty level)

Please include both **your information & your spouses information.

savings acct balance ______________ Do you own your home? yes no

checking acct balance ______________ Do you own other property? yes no

investment plan balances ______________ if yes, specify___________________________________

auto 1____ approx value_________________

auto 2____ approx value_________________

(make) (model) (year)

6. Expense information

type of debt	name of debtor	current balance	payments to date	monthly payment
mortgage / rent				
autos				
credit card				
credit card				
credit card				
banks/finance comp				
medical bills				
medical bills				
others				

7. Monthly household expenses

food ________________ auto expenses ________________ other ________________

elec/gas utilities ________________ prescription meds ________________ other ________________

water/sewer ________________ insurance ________________ other ________________

phone/cable/internet ________________ child care ________________ other ________________

Are you eligible for Medicare coverage? **yes** **no**

Have you applied for Wisconsin Badgercare? **yes, but ineligible** **Please provide determination letter.**

no, I have not applied

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT

____ ____________________________

(SIGNATURE) (DATE)