# INDIANHEAD MEDICAL CENTER

113 4th Ave, P.O. Box 300

Shell Lake, WI 54871

## Charity Care Adjustment Application

Charity Care Adjustments to an account may be made by the Indianhead Medical Center based upon Hospital Policy and household income level in comparison with current Federal Poverty Guidelines. To apply for a Charity Care Adjustment, you must LEGIBLY complete the attaced Financial Statement.

1. All questions must be answered completely and accurately.

2. All source of income for every member in your household must be accompanied by written proof of the amount of income (copies of paycheck stubs/checks/recent year income tax returns)

3. All related persons residing with the applicant must be identified by complete name, date of birth, and social security number if five years of age or older.

4. List all assets with current value. If property, the location of each property.

5. Signature and date must be included at the end of the financial by all residing in the household who is 18 years of age or older.

6. The information contained in this application is considered confidential, however, it may be shared with your physician and support personnel involved in your care as well as a committee that determines eligibility for charity assistance. Your signature on this application constitutes a release of information for the prior purposes.

   *PLEASE NOTE THAT YOUR SIGNATURE (AND ANY OTHERS) ARE VERIFYING THE ACCURACY OF THE INFORMATION INCLUDED IN THIS APPLICATION AS WELL AS AUTHORIZING THE HOSPITAL TO VERIFY ANY AND ALL INFORMATION PROVIDED FOR USE IN REVIEWING YOUR FINANCIAL.

Upon completion of our review and final decision, you will be notified of the results in writing.

If your application for Charity Care Adjustment is denied, you will be expected to take immediate steps to settle your account in full or make other arrangements for payment with the business office.

Information you are furnishing may be used in pursuit of collecting an account.

If you need assistance completing the financial, contact this office at (715)468-7833.

Return completed statement by:_____ to the address listed above.

# Financial Statement

*Charity Care Applicatio

Patient Name_____ Account _____

Responsible Party Name_____ Relationship to Patient_____

Address_____ City_____ State_____

Phone (home)_____ (work)_____

## Household Information

List EVERY member of your HOUSEHOLD including yourself and those listed above; give each person's social security number; state how each person is related to you; give their date of birth; and circle appropriate answer stating if each person is employed (Use an additional sheet, if necessary):

| NAME | SOCIAL SECURITY # | RELATION | DATE OF BIRTH | EMPLOYED |
|---|---|---|---|---|
| | | | | Yes/No |
| | | | | Yes/No |
| | | | | Yes/No |

## Employment Information

Complete the following information for each member of your household who is employed as indicated above. Proof of income (copies of pay stubs/copies of checks/recent income tax returns with all supporting statements and schedules) must accompany each section of employment. Use additional sheet if necessary to provide information for each person:

1. Name_____ Occupation_____ Gross Montly Income_____

   Employer Name_____ Phone_____

   Employer Addres_____

2. Name_____ Occupation_____ Gross Montly Income_____

   Employer Name_____ Phone_____

   Employer Addres_____

## Other Income

List all other income received during the past 12 months including unemployment compensation, rental income, child support, alimony, retirement, social security, food stamps, or any federal or state assistance of other sources:

| GROSS AMOUNT | SOURCE |
|---|---|
| $_____ | _____ |
| $_____ | _____ |
| $_____ | _____ |

# Concurrent Financial Statement

List all checking and savings accounts in a bank, savings and loan, or credit union:

| AMOUNT | ACCOUNT NUMBER | INSTITUTION NAME AND ADDRESS |
|---|---|---|
| $_____ | _____ | _____ |
| $_____ | _____ | _____ |
| $_____ | _____ | _____ |

OTHER CASH $_____

## Property and Assets

| Do you own: | Yes | No | Value | Description |
|---|---|---|---|---|
| House | ___ | ___ | _____ | _____ |
| Vehicle | ___ | ___ | _____ | _____ |
| Vehicle | ___ | ___ | _____ | _____ |
| Mobile Home | ___ | ___ | _____ | _____ |
| Land | ___ | ___ | _____ | _____ |
| Stocks/Bonds | ___ | ___ | _____ | _____ |
| Other | ___ | ___ | _____ | _____ |

****Use additional sheet if necessary****

## Monthly Debts

List all creditors, including banks, loan companies, charge accounts, rent, utilities, medical bills, medicines, etc.. Show specifically the total amount you currently owe and your monthly payments:

| Creditor/Address | Total | Monthly Payment |
|---|---|---|
| _____ | $_____ | _____ |
| _____ | $_____ | _____ |
| _____ | $_____ | _____ |
| _____ | $_____ | _____ |

***Use additional sheet if necessary****

## SIGNATURES

The information given on this form is true and confidential. I authorize Indianhead Medical Center to make whatever inquiries or verification it deems necessary in connection with this FINANCIAL STATEMENT. This section MUST be signed by every member of your household who is 18 years of age or older:

| Signature | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |