Prairie Ridge HEALTH
Inspired by you

Financial Disclosure
Application for Community Care

1515 Park Avenue · Columbus, WI 53925 · Phone 920-623-2200 · Fax 920-623-1508

Name_____ Soc. Sec. #_____ Birth Date_____

Address_____ Phone_____

City_____ State_____ Zip_____

Employer_____ Occupation_____

Spouse_____ Soc. Sec. #_____ Birth Date_____

Employer_____ Occupation_____

Dependents (name and relationship)

_____ Age_____ _____ Age_____

_____ Age_____ _____ Age_____

FAMILY INCOME: Represents total cash receipts for all sources before taxes including, but not limited to, wages, public assistance payments, social security, unemployment or worker's compensation 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, compensation for injury claims. Income is to be stated on a gross earnings/receipts basis. **Family income includes all income for family members indicated on the Federal 1040 Tax Form.**

SOURCE OF INCOME – Patient	Monthly Amount	Spouse/Other Family	Monthly Amount

REGULAR MONTHLY EXPENSES STATED ON A MINIMUM MONTHLY PAYMENT BASIS				
	Payment		Balance	Payment
Rent		Food		
Mortgage Payment		Utilities		
2nd Mortgage Payment		Transportation-Gas		
Alimony/Child Support		Medical Debt		
Insurance Premiums		Credit Card		
Continuous Medication		Other		

I hereby authorize Prairie Ridge Health, Inc. to verify this information as necessary, which may include obtaining employment or income verification, and appropriate supporting documentation to allow Prairie Ridge Health to evaluate my financial status and determine my eligibility for financial assistance programs.

I attest that the above information and all income documentation provided are complete and accurate as shown. Prairie Ridge Health reserves the right to request additional information and documentation for the purpose of determining eligibility for Community Care.

By applying for Community Care, I also agree to accept payment responsibility for any amount due from me as a result of any partial grant which may be awarded.

_____ _____
Applicant **Date**

_____ _____
Spouse/Family Member **Date**

Note: ***Proof of current income must be provided at the time of application, plus copies of your most recently filed Federal Income Tax Return***

HAVE YOU INCLUDED: ☐ Signed Application ☐ Federal 1040 Tax Return ☐ Proof of Income

***Proof of Income can include**: At least 2 Pay Stubs, Social Security Statement, Bank Statement, etc.*