MILE BLUFF MEDICAL CENTER, INC
FINANCIAL ASSISTANCE PROGRAMS APPLICATION

DATE: _____

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

Applicant for **community care program** or applicant for **sliding fee program** over 200% of FPL, complete all sections.
Applicant for sliding fee program at or below 200% of FPL, complete section 1 thru 4 & 8 only.

1. Applicant's general information

last name_____ first name_____ MI_____

birth date _____-_____-_____ Last four digits of SSN _____ 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 # _____-_____-_____

How long have you worked for this employer? _____ current hourly wage_____

pay cycle? ○ weekly ○ biweekly ○ monthly

Are you a student? ○ yes-full time ○ yes-part time ○ no

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

last name_____ first name_____ MI_____

birth date _____-_____-_____ Last four digits of SSN _____ day phone # _____-_____-_____

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 # _____-_____-_____

How long have you worked for this employer? _____ current hourly wage_____

pay cycle? ○ weekly ○ biweekly ○ monthly

Are you a student? ○ yes-full time ○ yes-part time ○ no

3. Others living in the same household

name_____ relationship_____ age_____

name_____ relationship_____ age_____

name_____ relationship_____ age_____

name_____ relationship_____ age_____
(additional, please attach separate page)

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 information

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

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	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	_____

8. Other sources of coverage

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)