MILE BLUFF MEDICAL CENTER, INC
FINANCIAL ASSISTANCE PROGRAMS APPLICATION

DATE:

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

Applicants applying for the Sliding Fee Scale at or below 200% of the Federal Poverty Level (FPL), complete sections 1-4.
Applications above 200% of the FPL must complete all sections on both pages

1. Applicant's general informatio

Last name_____ First name_____ MI_____

rth date ____/____/_ day phone # _____-_____-___ cell phone # _____-_____-_____

physical street address_____ city_____ zip_____

mailing address (if different)_____

employer_____ phone # _____-_____-_____

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

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

Are you a studen yes-full time yes-part time no

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

last name_____ first name_____ MI_____

birth date _____-_____-_____ 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?(circle one weekly biweekly monthly

Are you a studen yes-full time yes-part time no

3. Others living in the same househol

name_____ relationship_____ age_____

name_____ relationship_____ age_____

name_____ relationship_____ age_____

name_____ relationship_____ age_____
(additional, please attach separate pag

4. Income informatior

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

wages _____ social security _____ unemployment_____

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT

_____ _____
(SIGNATURE) (DATE)

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5. Assets information - Asset testing does not apply for families at and below 200% l

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 expense

food _____ auto expenses _____ other _____

elec/gas utilities _____ prescription meds _____ other _____

water/sewer _____ insurance _____ other _____

phone/cable/internet _____ child care _____ other _____

8. Other sources of coverag

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 **Please apply. If denied, provide determination letter.**

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT

_____ _____

(SIGNATURE) (DATE) rev 4/21/22