Holy Family Memorial

Required Documents Before Community Care Application Can Be Reviewed

Please provide **copies** of the following items:

- ❑ Most recent federal/state tax forms, including all schedules
- ❑ W-2 withholding statements if client didn't file taxes
- ❑ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months)
- ❑ Statement of monthly benefits from Social Security
- ❑ Forms approving or denying unemployment, worker's compensation or financial aid programs
- ❑ If unemployed, Manitowoc Job Center proof of visit for 4 weeks (Job Service print out)
- ❑ If uninsured but work and have dependent children, must apply for Badger Care and provide proof

Community Care Application Instructions & Selected Guidelines

- Non-medically necessary surgeries and procedures, and pharmacy drugs at retail stores are not eligible for Community Care. Appeals may be made in writing to the Chief Medical Officer of Holy Family Memorial.
- Be sure to include all persons living in the household as well as proof of their income(s) if they are working.
- The application must be complete. All expenses, income(s) and assets must be listed. Add additional sheet(s) if needed. Incomplete applications will be denied.
- All documentation indicated for proof of income is required to process the application.

  This information may include, but is not limited to: most recent tax form, including all schedules; paycheck/unemployment pay stubs; social security or pension income statements; disability payment statements, etc.
- Any application with falsified or deliberately omitted information will be denied. If it is discovered that information was falsified or deliberately omitted on previously approved applications, those discounts will be revoked.
- May request applicant to seek financial counseling.
- Information on the application may only be considered for up to six (6) months from the date the application was signed. If any further information is needed and is not received within the six (6) month time frame, a new and updated application must be completed for consideration.

Holy Family Memorial

Medical Excellence, Community Commitment

Sponsored by the Franciscan Sisters of Christian Charity

COMMUNITY CARE ELIGIBILITY APPLICATION

Last Name | First Name | Middle

Patient Name		Social Security No.
Address		Birth Date
Responsible Party Name	Account No.	Date of Treatment
Date of Application	Resp. Party Telephone No.	Resp. Party Social Security No.

LIST MEMBERS OF HOUSEHOLD

NAME	BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	UNIT/MR # (office only)
1.				
2.				
3.				
4.				
5.				
6.				

**** Proof of Income Required. Past 30 day check stubs and previous year tax return. ****

Primary Physician: _____

Insurance Information: _____

ID #: _____ **Group #:** _____

If eligible for Medicare, date eligible: _____

EXPENSE	MONTHLY PAYMENT / BALANCE
Rent / Mortgage Including Real Estate Taxes (Please Circle)	$ /
Utilities (Average)	$ /
Heat	$ /
Telephone	$ /
Transportation (Fees / Gas)	$ /
Food and Other	$ /
Insurance Premium: Car / Home / Rental (Please Circle)	$ /
Insurance Premium: Health / Life (Please Circle)	$ /
Pharmacy Expense	$ /
HFM Network Medical Debt and Any Other Medical Debt **(List Separately)**	
Name of Provider:	$ /
Name of Provider:	$ /
Name of Provider:	$ /
Name of Provider:	$ /
Loans	
Name of Creditor:	$ /
Name of Creditor:	$ /
Name of Creditor:	$ /
Name of Creditor:	$ /
Credit Cards	
Name of Creditor:	$ /
Name of Creditor:	$ /
Name of Creditor:	$ /
Name of Creditor:	$ /
Legal Fees / Fines	$ /
Child Support Payment	$ /
GRAND TOTAL EXPENSES	$ /

MONTHLY INCOME		ASSETS / CASH VALUE	
Head of Household Income (Gross)	$	Cash on Hand	$
Employer Name:		Institution - Checking	$
Other Household Income (Gross)	$	Institution - Savings	$
Employer Name:		Health Savings / Reimbursement Account	$
Other Income Source:	$	Trusts / Stocks	$
Unemployment Income	$	Primary Car (Make / Model / Year)	$
AFDC Income	$	Secondary Car (Make / Model / Year)	$
Pensions Income: ❑ Yes ❑ No	$	Retirement / 401K	$
Social Security Income: ❑ Yes ❑ No	$	Capital Gains	$
Interest Income	$	Inheritance / Gifts	$
Child Support Income	$	Sale of Property	$
Total Monthly Income	$	One-Time Insurance Settlement or Compensation for Injury	$
TOTAL YEARLY INCOME	$	**GRAND TOTAL ASSETS**	$

Patient / Responsible Party Explanation for Application:

INFORMED CONSENT

The information I have provided in this application is true to the best of my knowledge and belief.

I have read, understand, and agree to abide by the enclosed Community Care application instructions and selected guidelines.

I hereby authorize Holy Family Memorial to release any information necessary for verification of statements made on this application.

I hereby authorize release to Holy Family Memorial any information necessary for verification of statements made on this application. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my charges and I will take any action necessary to obtain such assistance.

This consent shall expire **six (6) months** from the date hereof. This consent is provided pursuant to section 146.81, Wis. Stat.

Patient Signature _____ Date _____

OFFICE USE ONLY

MEDICAL BILLS FOR ALL HFM NETWORK SERVICES

SITE	AMOUNT	SITE	AMOUNT
Holy Family Memorial Medical Center	$	Other	$
HFM Network Clinics	$	Other	$
Other	$	**Total HFM Network Medical Debt**	$

Date	**Patient Financial Advisor Recommendation:**
	Pharmacy / DME: $_____
	Health Insurance Premium: $_____
	Total All Medical Debt: $_____ Medical Debt Percent: _____
	Community Care Committee Approval / Denial:
	Patient Co-Payment: $_____ Co-Pay Facility: _____

Patient Financial Advisor

Network Site

7/08