CUMBERLAND HEALTHCARE

1110 Seventh Avenue
Cumberland, WI 54829
Telephone: 715-822-7500
FAX: 715-822-7221

FINANCIAL ASSISTANCE APPLICATION

Please provide the following information completely and accurately. Information is subject to verification.

Patient's Name:_____ Social Security#:_____

Address:_____

Home Telephone #:_____ Cell Phone #:_____

Employer Information (Patient/Responsible Party):

_____

List **ALL** Household Members Name (see page 2):

Please attach a list of additional household members if there are more than five (5) member.

Name	Date of Birth	Social Security Number	Relationship To Patient	Monthly Income

MONTHLY INCOME (Total household income)

Gross Income (before taxes) _____

Other Household Gross Income: _____

Investment Income: _____

Child Support/Alimony: _____

Rental Property Income: _____

Pension/Retirement: _____

Unemployment Income: _____

Other Income: _____

Please attach the following proof of income documents: Federal tax return for previous year, payroll stubs for last 2 months, bank statements for current month and any other income verification.

MONTHLY EXPENSES

Rent: _____

Mortgage: _____

Phone: _____

Cable: _____

Car Loan: _____

Insurance: _____

Other: _____

TOTAL MONTHLY EXPENSES: _____

HEALTH INSURANCE COVERAGE

Is health insurance coverage available to you through an employer or other source? Yes No

If yes, do you participate? Yes No

If yes please provide the following:

Name of Insurance: _____

Subscriber: _____

Policy and Group Number: _____

If no, why did you choose not to participate? _____

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services rendered to me by Cumberland Memorial Hospital. I understand that providing false information will result in denial of the application for any type of financial assistance through Cumberland Memorial Hospital.

_____ _____

Signature of Patient/Responsible Party Date