



1705 16<sup>th</sup> 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, and 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 Healthcare. I understand that providing false information will result in denial of the application for any type of financial assistance through Cumberland Healthcare.

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Signature of Patient/Responsible Party

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Date