

**COMMUNITY CARE PROGRAM  
ELIGIBILITY APPLICATION**



**Memorial Medical Center**  
Neillsville, Loyal, Greenwood  
Care...at its best

216 Sunset Place  
Neillsville WI 54456  
715-743-3101

Applicant: \_\_\_\_\_ Age: \_\_\_\_\_ Spouse: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_  
 Time at Present Address: \_\_\_\_\_ Phone: \_\_\_\_\_ # in Household \_\_\_\_\_

**Applicant**

**Spouse/Significant Other**

Employment Status:       Full-time     Part-time     Lay off  
     Temporary Leave     Unemployed

Primary/Last/Current Employer: \_\_\_\_\_

Business Address: ..... \_\_\_\_\_

Business Phone:..... \_\_\_\_\_

Occupation: ..... \_\_\_\_\_

Start of Employment:..... \_\_\_\_\_

Last Date of Employment:..... \_\_\_\_\_

Social Security No.:..... \_\_\_\_\_

Full-time     Part-time     Lay off  
 Temporary Leave     Unemployed

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Household Members (List each by name):

\_\_\_\_\_ Age: \_\_\_\_\_      \_\_\_\_\_ Age: \_\_\_\_\_      \_\_\_\_\_ Age: \_\_\_\_\_  
 \_\_\_\_\_ Age: \_\_\_\_\_      \_\_\_\_\_ Age: \_\_\_\_\_      \_\_\_\_\_ Age: \_\_\_\_\_

**Did you file Taxes last year?** \_\_\_\_\_ (if yes, you must include a complete copy of your taxes)

***INCOME (Applicant and Spouse/Significant Other)***

**Total household income from all sources before taxes ~ PROOF OF INCOME IS REQUIRED.**

***SOURCE(S) OF INCOME (Check all that apply and include the Annual Amount)***

**Annual Amount:**

<input type="checkbox"/> Wages _____	_____
<input type="checkbox"/> Social Security _____	_____
<input type="checkbox"/> Unemployment _____	_____
<input type="checkbox"/> Retirement _____	_____
<input type="checkbox"/> Tax Refund _____	_____
<input type="checkbox"/> Alimony/Child Support _____	_____
<input type="checkbox"/> Other _____	_____

***Attach proof of income – Last two check stubs for all Sources of Income listed above***

**COMMUNITY CARE PROGRAM  
ELIGIBILITY APPLICATION**



**ASSETS – SAVINGS (Applicant & Spouse/Significant Other combined)**

<u>Type</u>	<u>Financial Institution</u>	<u>Phone #</u>	<u>Account #</u>	<u>Amount</u>
Checking :	_____	_____	_____	\$ _____
Savings/CD/ Investments:	_____	_____	_____	\$ _____
Other:	_____	_____	_____	\$ _____

*Please include last 3 months of Bank Statements*

**ASSETS - PROPERTY**

Home – Location: \_\_\_\_\_  
 Fair Market Value: \$ \_\_\_\_\_ Mortgage Balance: \$ \_\_\_\_\_  
 Lending Institution: \_\_\_\_\_

Other Property – Location: \_\_\_\_\_  
 Fair Market Value: \$ \_\_\_\_\_ Mortgage Balance: \$ \_\_\_\_\_  
 Lending Institution: \_\_\_\_\_

*Include copy of property taxes for each property owned.*

**OTHER ASSETS (Vehicles, Boats, ATV's, Motorcycles, Snowmobiles, etc.)**

<u>Description</u>	<u>Estimated Value</u>	<u>Loan Balance</u>
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

**REGULAR MONTHLY PAYMENTS**

**Estimated Monthly Payments**

Rent or Mortgage Payment	\$ _____	Utilities:	\$ _____
Alimony or Child Support	\$ _____	Insurance:	\$ _____
Auto Loan Payments	\$ _____	Phone:	\$ _____
Other Loan Payments	\$ _____	Credit Cards:	\$ _____

Please include a few comments that explain your current financial situation and why you are applying for Community Care:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I attest that the above information is accurate to the best of my knowledge and truly represents my current financial status.

I authorize Memorial Medical Center to verify any information given on this financial statement, and to run a credit report if necessary to process this application.

\_\_\_\_\_  
 Signature of Patient or Responsible Party

\_\_\_\_\_  
 Date