



Financial Statement

Hospital & Clinics 608-262-2221
 600 Highland Ave 866-841-8535
 Madison, WI 53717 608-265-0185, Fax

Physicians 608-829-5254
 7974 UW Health Ct. 877-565-8855
 Middleton, WI 53562 608-833-5039, Fax

Person completing form: _____ **Date completed:** _____

Please list all family members who have patient balances that you would like considered for the Community Care program.

Patient name: _____ Medical Record #: _____ Birth date: _____
 Patient name: _____ Medical Record #: _____ Birth date: _____
 Patient name: _____ Medical Record #: _____ Birth date: _____
 Patient name: _____ Medical Record #: _____ Birth date: _____

GUARANTOR: _____ Rel. to Patient: _____ **SPOUSE:** _____

Address: _____ Address: _____

County: _____ Home Phone: _____ County: _____ Home Phone: _____

Employer: _____ Empl. Date: _____ Employer: _____ Empl. Date: _____

Employer Address: _____ Employer Address: _____

Employer Phone: _____ Employer Phone: _____

If unemployed, last day/mo & yr worked: _____ If unemployed, last day/mo & yr worked: _____

Marital Status (check one): Married Single Separated Divorced Widowed

Monthly income received by guarantor (and spouse, if applicable)

Monthly Income: _____ Gross: _____ Net: _____ Monthly Income: _____ Gross: _____ Net: _____

Full Time Part Time Hourly Wage: _____ Full Time Part Time Hourly Wage: _____

Job Title: _____ Job Title: _____

Monthly Soc. Sec. Income: _____ Monthly Soc. Sec. Income: _____

SS Disability SSI SS Retirement SS Survivor Benefit SS Disability SSI SS Retirement SS Survivor Benefit

SSDI Applied For: _____ Date: _____ SSDI Applied For: _____ Date: _____

Pension: _____ Rental Income: _____ Pension: _____ Rental Income: _____

Unemployment: _____ Cert of Dep./IRA: _____ Unemployment: _____ Cert of Dep./IRA: _____

401K: _____ Other: _____ 401K: _____ Other: _____

Checking Acct. Avg. Mo Balance: _____ Checking Acct. Avg. Mo Balance: _____

Name of Bank: _____ Name of Bank: _____

Savings Acct. Balance: _____ Savings Acct. Balance: _____

Name of Bank: _____ Name of Bank: _____

DEPENDENTS	Age	Joint Custody (Y/N)	Does Child Live With You? (Y/N)	How Much	Is Other Parent on MA? (Y/N)	Monthly Support	Paid? Rcvd?

Assets

Automobile make/model: _____ Own/lease: _____ Year: _____ Balance owed: _____

Automobile make/model: _____ Own/lease: _____ Year: _____ Balance owed: _____

Real Estate value: _____ Balance on Mortgage: _____

Did you file taxes last year? Yes (Please attach copy) No Reason: _____

Monthly Household Expenses

Rent: _____ Cable TV: _____ Food: _____

Mortgage: _____ Telephone: _____ Car Payments: _____

Real Estate Taxes: _____ Cell Phone: _____ Gasoline: _____

Heat: _____ Child care: _____ Tuition: _____

Electric: _____ Medication: _____ Other (tax-deferred contributions): _____

Water/sewer: _____ Clothing: _____ Insurance Expense: _____

Auto Home/Renter's Life Health

Remarks: _____

Household / Family Medical and Other Bills Owed by Guarantor (and Spouse, if Applicable)

<i>Hospital / Doctor / Clinic (List Names):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

<i>Bank Loans / Credit Cards / or Other Bills (List use):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

(If you have additional expenses, please attach a separate sheet)

To better serve our patients, the University of Wisconsin Medical Foundation and University of Wisconsin Hospital and Clinics coordinate by using a single form. I understand this information will be used only for determination of financial responsibility for my charges at the University of Wisconsin Medical Foundation and University of Wisconsin Hospital and Clinics and will be kept confidential. My signature authorizes the UW Medical Foundation and UW Hospital and Clinics to verify any information furnished on this form.

To the best of my knowledge, the information provided above is true and correct:

Patient/Guarantor Signature: _____ Date: _____

Signature of person completing form if different from patient: _____ Date: _____

<p>For evaluation with the Community Care Program, please include the following items:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Completed Financial Statement (both pages filled out entirely and signed) <input type="checkbox"/> Last year's Federal Taxes including all tax schedules (if applicable) <input type="checkbox"/> Current pay stubs / unemployment statements <input type="checkbox"/> *If you are currently not employed or have not filed taxes, submit a signed letter explaining how you meet your daily living expenses. If you receive Social Security income due to age or disability, please include either a copy of your benefits statement from the Social Security Administration or a copy of your bank statement showing the direct deposit
--