

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

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

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

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: _____

Emergency Contact Name: _____ Emergency Contact Name: _____

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 (List Hospital Names):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. UW Hospital & Clinics (866) 841-8535 _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

<i>Doctor/Clinic (List Names):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. UW Health Physicians (877) 565-8855 _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

<i>Bank/Credit Union Loans (List Purpose of Loan):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. _____	_____	_____
2. _____	_____	_____

<i>Credit Cards or Other Bills (List Reasons for Use):</i>	<i>Balance:</i>	<i>Monthly Payment:</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

If you have additional expenses, please attach a separate sheet. **Please enclose a copy of your last tax return and last two payroll check stubs to verify income.** If your only income is Social Security, please enclose a copy of your Social Security Award Letter OR 2 bank statements showing the direct deposit.

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: _____

Form completed with patient via phone