Marshfield Medical Center
Park Falls

COMMUNITY CARE FINANCIAL ASSISTANCE APPLICATION

Date: _____

Applicant Name:		**Spouse's Name:**
Date of Birth:		**Date of Birth:**
Address:		
City:	**State:**	**Zip:**
Home Phone: ( ) -		**Cell Phone: ( ) -**
Number of Dependents:		**Dates of Birth of <u>all</u> household members:**

EMPLOYMENT

	Applicant		**Spouse**	
Employer 1:				
For How Long:				
Hourly Wage:	$	_____hrs/wk	$	_____hrs/wk

Employer 2:				
For How Long:				
Hourly Wage:	$	_____hrs/wk	$	_____hrs/wk

Employer 3:				
For How Long:				
Hourly Wage:	$	_____hrs/wk	$	_____hrs/wk

Employer 4:				
For How Long:				
Hourly Wage:	$	_____hrs/wk	$	_____hrs/wk

(please add additional employers on back)

Marshfield Medical Center
Park Falls

INCOME

	Applicant		Spouse	
	Monthly	Year to Date	Monthly	Year to Date
Gross Wages				
Social Security				
Retirement/Pension				
Worker's Comp				
Unemployment				
Child Support				
Other (_____)				
Other (_____)				
TOTALS				

ASSETS

	Financial Institution	Amount
Savings		
Checking		
HSA		
Other		

PLEASE PROVIDE COPIES OF: **(Additional documents may be requested upon review of the application)**

- ☐ Your last **3 MONTHS** worth of **ALL** Bank statements.
- ☐ Your most recent tax return (if you did not file taxes, please fill out IRS Form 4506-T).
- ☐ Your most recent W-2 and 1099 forms.
- ☐ Your most recent paycheck stub for each employer.
- ☐ *If applicable*, a determination letter or supporting documentation for: Social Security; Unemployment; Child Support.

Marshfield Medical Center
Park Falls

OTHER

	Yes	No
Are you a Veteran?		
Are you currently enrolled in Medicaid?		
Are you eligible for Medicaid?		
Have you applied but been denied for Medicaid?		
Do you have any disabilities?		
Do you have an open disability case?		
Do you receive Medicare or Social Security benefits?		

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to this application.

Applicant Signature _____ Date _____ Spouse Signature _____ Date _____

Please list the Marshfield Medical Center-Park Falls account numbers that you are requesting assistance for:

_____ _____ _____

_____ _____ _____

If you have questions, please call the Marshfield Medical Center-Park Falls Business Office at: (715) 762-7557

Please return application and all documents to:

Marshfield Medical Center-Park Falls
Attn: Community Care
PO Box 310
Park Falls, WI 54552