# Instructions for Completing the Community Care Application

There are three parts of the Community Care Application that are required to determine your eligibility. After receiving all information, your application will be evaluated and you will be notified in writing of the results. **Return all requested information in 10 days.**

Please note that all other sources of funding must be used before Community Care Funds are available.

**Part 1 -** The Community Care Application, which is enclosed, must be completed.

**Part 2 -** A copy of your most recent Federal Income Tax Form 1040, including all schedules and papers sent to the Internal Revenue Service.

**Part 3 -** All of the following items that apply to your situation must accompany the completed Community Care Application:

- **If you and/or spouse are employed** – copies of **3 months** of your most recent pay check stubs or a letter from your employer indicating what your gross earnings were for the most recent 3 months.
- **If you and/or your spouse have a checking and/or savings account** – copies of the most recent bank statements.
- **If you and/or your spouse received unemployment compensation** – copies of your check stubs or a statement of those earnings, which you can get from the unemployment office.
- **If you received any type of assistance or maintenance payments** – copies of your check stubs, award letters, or a statement indicating your monthly benefit amount such as child support, alimony, housing allowance, food stamps, etc.
- **If you and/or your spouse receive a pension** – a copy of your check or check stub.
- **If you and/or your spouse receive social security** – a copy of your benefit award letter for the current year, a copy of your check, or a copy of your bank statement if it is direct deposited to your account.
- **If you have other medical/credit card debt** – verification of balance is required, such as statements.

**NOTE: THIS DOES NOT MEAN BELLIN HEALTH WILL BE ADJUSTING BILLS WITH OTHER AGENCIES OR PROVIDERS – PLEASE CONTACT THEIR OFFICE.**

**If the information is not complete, the application cannot be processed and will be returned to you to be completed.**

**Please submit the completed Community Care information to:**

Bellin Health Business Office
Attn: Cathy – Community Care
PO Box 22487
Green Bay, WI 54305-2487

If you have any questions, please call me at (920) 445-7210 ext 7715.

P.O. Box 22478, Green Bay, WI 54305-2487

# COMMUNITY CARE APPLICATION

*(Aplicacion de Cuidado Comunitario)*

Guarantor Name ______________________________________________
(Nombre del Garantor) Last (Apellido) First (Primer Nombre) MI (Inicial del segundo nombre)

Address ______________________________________________ City/State ______________________ Zip __________
(Dirección) (Ciudad/Estado) (Código Postal)

Birth date ________________________ Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Separated ☐ Divorced
(Fecha de Nacimiento) (Estatus Marital) (Casado) (Soltero) (Compañera) (Separado) (Divorciado)

Phone Number (Home)_________________ (Work)________________________ (Cell)__________________________
(Número de Teléfono) (Hogar) (Trabajo) (Celular)

Patient Name (if different than guarantor) ____________________________________________ Birth date ________________
(Nombre del Paciente) (si difiere del garantor) Last (Apellido) First (Primer Nombre) MI (Inicial del segundo nombre) (Fecha de Nacimiento)

Number of people living in your home ________ Number of dependent children living in your home _______
(Número de personas viviendo en su hogar) (Número de niños dependientes viviendo en su hogar)

Did you file Federal and State taxes for the previous year? ☐ Y ☐ N Have you applied for BadgerCare? ☐ Y ☐ N
(¿Registro usted impuestos estatales y federales del año anterior?) (¿Ha aplicado usted por BadgerCare?)

## Guarantor Income (Ingreso del Garantor)

Are you currently employed? ☐ Y ☐ N Employer ______________________________ Start date __________________
(¿Esta trabajando actualmente?) (Empleador) (Fecha de Inicio)

Does your employer offer health insurance? ☐ Y ☐ N Hourly Wage ______________ Hours per week ___________
(¿Ofrece su empleador seguro médico?) (Salario por hora) (Horas por semana)

Are you a full-time student? ☐ Y ☐ N Name of School ______________________________________________
(¿Es usted estudiante de tiempo completo?) (Nombre de la escuela)

Social Security/Disability $____________ Pension $_______________ Unemployment Compensation $_____________
(Seguro Social / Incapacidad) (Pensión) (Compensación por Desempleo)

Alimony/Maintenance $_______________ Child Support $_______________ Housing Allowance $________________
(Manutención/Mantenimiento) (Manutención de Menores) (Compensación de vivienda)

Interest Income $________________ Rental Income $___________________ Other Income $______________________
(Ingreso de Intereses) (Ingreso de Renta) (Otro ingreso)

If you have no source of income, how have you been supporting yourself? (Si usted no tiene ingresos, ¿cómo se ha podido mantener?)________________________________________________________________________

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## Other Household Income (Otros Ingresos del Hogar)

Name ______________________________ Relationship ____________________
(Nombre) Last (Apellido) First (Primer Nombre) MI (Inicial del segundo nombre) (Relación)

Employer ______________________________ Start date __________ Hourly Wage ________
(Empleador) (Fecha de Inicio) (Salario por hora)

Hours per week ________ Are you a full-time student? ☐ Y ☐ N Name of school ____________________
(Horas por semana) (¿Es usted estudiante de tiempo completo?) (Nombre de la escuela)

Social Security/Disability $__________ Pension $____________ Unemployment Compensation $__________
(Seguro Social / Incapacidad) (Pensión) (Compensación por Desempleo)

Alimony/Maintenance $____________ Child Support $____________ Housing Allowance $____________
(Manutención/Mantenimiento) (Manutención de Menores) (Compensación de vivienda)

Interest Income $______________ Rental Income $________________ Other Income $________________
(Ingreso de Intereses) (Ingreso de Renta) (Otro ingreso)

## Assets (Activos)

Checking account $________________ Savings account $________________ 401K $____________________
(Cuenta Corriente) (Cuenta de Ahorros) (401K)

Stocks or Bonds $_________________ Certificates of deposit $____________ 403B $__________________
(Acciones o Bonos) (Depósitos a Plazo Fijo) (403B)

Pension Fund $___________________ Annuities $_____________________ IRA $____________________
(Fondo de Pensión) (Anualidades) (IRA)

Do you own your home? ☐ Y ☐ N Fair market value $________________ Balance owed $________________
(Es propietario (a) de su vivienda) (Valor justo del mercado) (Saldo a deber)

Do you own your own business? ☐ Y ☐ N Value $____________________ Balance owed $________________
(Es propietario (a) de un negocio) (Valor) (Saldo a deber)

Do you own other land or buildings? ☐ Y ☐ N Value $________________ Balance owed $________________
(Es propietario (a) de terrenos o edificios) (Valor) (Saldo a deber)

## Medical & Credit Card Debt (Deudas por Gastos Médicos y Deudas Con Tarjetas de Crédito)

Credit Card Debt (Deudas Con Tarjeta de Crédito) $____________________ provide statements (Provea extractos)

Other Hospital Debt (Otras Deudas del Hospital) $____________________ provide statements (Provea extractos)

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.), which may be applicable for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

(Certifico que la información anteriormente presentada es veraz y correcta según mi leal saber y entender. Asimismo, solicitaré todo tipo de ayuda tal como (Medicaid, Medicare, seguro, etc.) disponibles para pagar mis gastos en el hospital. Tomaré todas las medidas razonables y necesarias para obtener dicha ayuda, y le asignaré y pagaré al hospital el monto recuperado para dichos gastos. Si cualquier dato o información que haya proporcionado se prueba que es falso, entiendo que el hospital puede volver a evaluar mi situación financiera y tomar cualquier medida que sea apropiada.)

Date of Request ______________________________ Applicant's Signature ______________________________
(Fecha de la Solicitud) (Firma del Solicitante)