



BALDWIN AREA MEDICAL CENTER, INC.
730 10TH AVENUE
BALDWIN WI 54002
715-684-5172

IF YOU HAVE ANY QUESTIONS ON THE APPLICATION, PLEASE CALL

Community Care Application

Applicant: _____ Date of Birth: _____

Street address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Spouse's Name: _____ Date of Birth: _____

Veteran: [] No [] Yes If yes, have you applied for the Veteran's Grant? _____

Applicant

Spouse

Employer: _____

Employer Address: _____

Employer Phone: _____

Date of Hire: _____

Date of Term: _____

Previous Employer/Dates: _____

Social Security #: _____

Health Insurance Policy: _____ Policy #: _____ Enrollment Date: _____

Does your Employer have Health Insurance Available? _____

Table with 6 columns: Dependents Name (claimed on taxes), Age, Relationship, Dependents Name, Age, Relationship. Rows 1-4.

Are any of the BAMC balances that are outstanding the result of a workman compensation or liability (accident) date? _____
Please list applicable dates of service here: _____

List Current Monthly Income (Indicate Amount and Provide Documentation Supporting Each Reported Amount):

[] None: How do you support yourself? _____
(If someone is assisting you, have them provide a letter stating this and send with your application)

[] Wages _____ [] Veterans _____ [] Pension _____

[] Child Support _____ [] Alimony _____ [] Social Security _____

Give amounts and dates you have been receiving the following:

[] Workers Comp \$ _____ [] Unemployment \$ _____ [] Other \$ _____
Dates _____ Dates: _____ Dates: _____

List Your Asset Amounts:

Savings: _____ Checking: _____ Property: _____
 IRA: _____ Stocks/Bonds: _____ Non-stead property: _____

RELEASE OF FINANCIAL INFORMATION

I, _____, authorize the Baldwin Area Medical Center, Inc. Community Care Program to obtain any financial information held by the Social Security Administration, County Social Services, lending institutions or insurance companies on myself, for the purpose of determining eligibility for Community Care funding. This authorization is valid for 90 days from my dated signature. I can revoke it at any time, except, to the extent that the medical center has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original. I hereby certify that information on this application is correct.

Signature of Applicant: _____ Date: _____

Reason for Application: I understand that the Community Care Program is not an insurance program nor is it an entitlement program. It is not meant to replace benefits that are, or could be, received from government-supported or other payment programs. I further understand that I am expected to exhaust all other payment options as a condition of approval for discount consideration under the Community Care Program. My basis for application at this time is:

Signature of Applicant: _____ Date: _____

If signed by person other than the patient, complete the following:

Signature of legally authorized person: _____ Date: _____
 Patient is: () minor () incompetent () disabled Legal Authority: () legal guardian () parent of minor

YOUR APPLICATION CANNOT BE PROCESSED UNTIL YOU HAVE:

Completed:

- 1) Community Care Application.
- 2) Provide verification of Income. We require verification of income for the last two years.
- 3) Medical Assistance Application within the last 90 days. If you are denied, please provide copy of the denial.
 - Applications can be obtain from this web site: www.access.wisconsin.gov/access/ or call 1-800-292-2002.

Attach

- Copy of your last two years Federal Income Tax forms.
 - If you did not file income tax, provide documentation for the previous 12 months outlining your income.
- Federal Poverty Guidelines** – The Federal Poverty Guidelines (FPG) shall be the poverty guidelines as established at the Federal level and as annually published in the Federal Register this includes bank statements for checking and savings.
- If you are unable to work, you must have applied for disability and provide verification of that application and a copy of any denial. You will be expected to process and submit an appeal of any initial denial for disability coverage.

Important:

1. Until your application is approved, your accounts are at risk for outside collection activity.
2. Incomplete applications will be returned.