

CONFIDENTIAL FINANCIAL STATEMENT

PLEASE COMPLETE THIS FORM, SIGN, DATE AND INCLUDE THE FOLLOWING INFORMATION.

To process your application we will need:

- **Proof of income** (ex.: prior year 1st page income tax return, 90 days pay vouchers, or 90 days bank statements)

- **Proof of dependents**

- **Complete the following information**

Patient Name _____

Birth Date _____

Social Security Number _____

Responsible Party _____

Address _____

City _____

State _____ Zip _____

Telephone _____

Marital Status: Single/Married/Divorced

Health Insurance/Group Plan:

Dependents

Name/Relationship/Birth Date

Patient Income Source:

Employer: _____

Address: _____

City: _____ State: _____ Zip _____

How Long _____ to _____
(Month/Year) (Month/Year)

Wages \$ _____

Spouse Income Source:

Employer: _____

Address: _____

City: _____ State: _____ Zip _____

How Long _____ to _____
(Month/Year) (Month/Year)

Wages \$ _____

Total Wages \$ _____

Social Security \$ _____

Unemployment Comp \$ _____

Alimony \$ _____

Child Support \$ _____

Pension \$ _____

Source _____

Interest \$ _____

Source _____

Other Income \$ _____

Total \$ _____

Monthly Household Expenses

Mortgage/Rent \$ _____

Property Taxes \$ _____

Income Taxes \$ _____

Utilities \$ _____

Car payments \$ _____

Credit Card Payments \$ _____

Installment Loans \$ _____

Transportation \$ _____

Food \$ _____

Insurance \$ _____

Alimony/Child Support .. \$ _____

Medical Expenses \$ _____

Total \$ _____

Assets

Savings \$ _____

Institution \$ _____

Checking \$ _____

Institution \$ _____

Cash \$ _____

Stocks/Bonds \$ _____

IRA/CD Accounts \$ _____

Motor Vehicles \$ _____

Make _____ Year _____

Make _____ Year _____

1st Home Value _____ Payment _____

2nd Home Value _____ Payment _____

Debts

To Whom Owed	Amount	Payment
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Mission

Faithful to the spirit of the Hospital Sisters of the Third Order of St. Francis, St. Nicholas Hospital is dedicated to suffering humanity for His sake.

Vision

We will bring Christ’s healing presence to all who come to us by providing family-centered, compassionate care without regard for race, creed, or ability to pay.

Values

Our core values of respect, care, competence, and joy, will be lived by all who work here and felt by all who use our services.



St. Nicholas Hospital

Community Care Application



St. Nicholas Hospital offers financial assistance to those patients in need.

Guidelines have been established to ensure that the Hospital’s limited resources are used to treat patients who are truly unable to pay and are not consumed by those unwilling to pay or who have alternative pay sources.



St. Nicholas Hospital

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www.stnicholashospital.org

An Affiliate of Hospital Sisters Health System

Please read and sign the statement below.

- I am currently employed.
- I am currently unemployed and do not have any income at this time.

I certify that all information on this form is true and correct. I also understand that if the information I submit is not or at any time in the future determined false, such a determination will result in current and/or retroactive denial of Community Care and that I will be liable for charges for services rendered.

Signature Date

Witness Date