



CONFIDENTIAL FINANCIAL STATEMENT/ REQUEST FOR COMMUNITY CARE

Please complete both sides of this form. Return the signed form with all required documents to the address below.

Patient Financial Service, P.O. Box 13508, Green Bay WI, 54307

Name: _____ Birthdate: _____ SSN: _____
(Patient) (month/day/year)

Name: _____ Birthdate: _____ SSN: _____
(Guarantor) (month/day/year)

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone No.: _____ Work Phone No.: _____ Cell Phone No.: _____

Marital Status: _____ Number of people living in your home: _____ Number of dependent children _____

GUARANTOR INCOME

Employer Name: _____

Address: _____

City: _____ State _____ Zip _____

Date Started: _____ Wage: _____
(month/year) (per hour)

Hours per week: _____

Are you a full-time student? YES NO

Name of School: _____

Social Security/Disability: _____

Unemployment Comp: _____

Alimony/Maintenance: _____

Support Payments: _____

Housing Allowance: _____

Pension: _____ Source: _____

Rental Income: _____ Source: _____

Interest Income: _____ Source: _____

Other Income: _____ Source: _____

Total Monthly Income \$ _____

OTHER HOUSEHOLD INCOME

Relationship to Guarantor: _____

Employer Name: _____

Address: _____

City: _____ State _____ Zip _____

Date Started: _____ Wage: _____
(month/year) (per hour)

Hours per week: _____ Are you a full-time student? YES NO

Name of School: _____

Social Security/Disability: _____

Unemployment Comp: _____

Alimony/Maintenance: _____

Support Payments: _____

Housing Allowance: _____

Pension: _____ Source: _____

Rental Income: _____ Source: _____

Interest Income: _____ Source: _____

Other Income: _____ Source: _____

Total Monthly Income \$ _____

If you have no source of income, how have you been supporting yourself? _____

