Debts

To Whom Owed	Amount	Payment
____________________	$_______	$______
____________________	$_______	$______
____________________	$_______	$______
____________________	$_______	$______

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*

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

3100 Superior Avenue
Sheboygan, WI 53081
Phone (920) 459-4627
Fax (920) 451-7411
www.stnicholashospital.org

An Affiliate of Hospital Sisters Health System

BS00001 12/07

area for numbering

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.

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 ________