UNITED HOSPITAL SYSTEM, INC.
COMMUNITY CARE FINANCIAL APPLICATION

PLEASE READ CAREFULLY! In order for us to process your application for assistance, proof of income must be attached.

Please note: Any blank spaces may disqualify or delay processing of your application. **Complete this form in ink**.

Please attach the following Requirements: Return by __________________

☒ Current Pay Stub ☒ Latest Tax Return ___________(Federal, State and W-2's)

☒ Current Bank Statements ☒ Letter of Financial situation ☒ Picture I.D.

Please mail the completed form to: UHSI 6308 Eighth Avenue Kenosha, WI. 53143-5082

For questions, call ____________________________at _____________________________

Date: ________________________ Account Number(s) ____

Patient Name ____________________________________Patient Date of Birth_____________________

Address:____

City, State, Zip Code: ____

Patient Phone No. _______________________________ SSN _____________________________

Marital Status: ____ single ____ married ____ widowed ____ divorced ____ separated

Spouse Name: ______________________________________Spouse Date of Birth_________________

Number of dependents _______

Dependent Name: ____Date of Birth: __________

Dependent Name:____Date of Birth: __________

Dependent Name: ____Date of Birth: __________

Dependent Name: ____Date of Birth: __________

Dependent Name: ____Date of Birth: __________

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED!):

Are you presently employed? ☐ Yes ☐ No Are you self-employed? ☐ Yes ☐ No

Patient or Parent			**Spouse or Parent**		
Present or Last Employer			Present or Last Employer		
Street Address	Telephone #		Street Address	Telephone #	
City	State	Zip	City	State	Zip
Supervisor's Name	Telephone #		Supervisor's Name	Telephone #	
Monthly net income			Monthly net income		
Employment Dates From: ___________ To: _________ (Require previous employment information if short term)			Employment Dates From: ___________ To: _________ (Require previous employment information if short term)		

OTHER SOURCES OF INCOME (check type and list amount):

☐ Alimony / Child Support______________ ☐ Pension Annuity__________________________

☐ Social Security______________________ ☐ Workmen's Compensation___________________

☐ Veterans Pension____________________ ☐ Rental Income__________________________

☐ Unemployment Compensation__________________

☐ Other (specify) ____________________________

APPLICANT ASSET DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Checking				
Savings				
CDs. IRAs, etc.				
Stocks, Bonds, etc.				
Cash on Hand				
Income Property				
Other Assets (boat, motorcycle, snowmobile, etc)				

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to United Hospital System, Inc. for verification of this financial statement.

_______________________________________ _______________________

Signature of Patient / Guarantor / Spouse Date

_______________________________________ _______________________

UHSI Provider Representative Date

****** A copy of your current tax return must accompany this form.