

**Sauk Prairie Memorial Hospital & Clinics
Community Care Program Eligibility Application**

Name: _____ DOB: _____ Spouse: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone _____ # Family Members _____ # Minors _____

	Patient	Spouse
Social Security #	_____	_____

Employed By: _____

Business Address: _____

Business Phone: _____

Occupation: _____

Length Employment: _____

Is insurance offered through your or your spouse's employer? ____ Yes ____ No

If yes reason insurance was not taken _____

Dependents (list each by name):

_____ Age: _____ _____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____ _____ Age: _____

INCOME:

Represents **total household income from all adult sources*** before taxes including wages, public assistance payments, social security, unemployment or workers' compensation benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust income, tax refunds, compensation for injury claims. *A student listed on your income tax form as a dependant is not included in the household income. Students, age 24 under, do not need to list income from other adult sources within the household.

PROOF OF INCOME IS REQUIRED. Please attach copies of your last two wage statements (check stubs) and your most recent income tax return. Notification letters indicating monthly benefit amounts are required for Social Security and other government program recipients.

SOURCE(S) OF INCOME: _____ **Annual Amount:** _____

_____ \$ _____

_____ \$ _____

Attach proof of income for all Sources of Income listed above

