



Send the completed form and supporting documentation to:
 Columbia Center
 Business Office
 P.O. Box 311
 Pewaukee, WI 53072

Columbia Center Financial Assistance Application

If you need assistance completing this application, please call our customer service department for any help at 262-446-0240.

PLEASE TYPE OR PRINT: ALL INFORMATION MUST BE COMPLETED. Patient Account Number _____

Patient Name _____ Address _____

City/State/Zip _____ County _____ Sex Male Female

Telephone _____ Birthdate (M/D/Y) _____ Social Security Number _____ Length of Residency _____

Responsible Party _____ Relationship _____ Social Security Number _____ Length of Residency _____

Number of Dependents _____ Name(s) & Ages of Dependents _____

Present or Last Employer (Patient) _____ Present or Last Employer (Spouse) _____

Address _____ Address _____

Telephone _____ Length of Employment _____ Telephone _____ Length of Employment _____

Occupation (Patient) _____ Occupation (Spouse) _____

Sources of Income *Patient* *Spouse*

Salaries, Wages & Unemployment _____

Pensions/Social Security _____

Interest & Dividends _____

Business/Rental _____

Child Support/Alimony _____

Estate or Trust _____

Injury Claims _____

All Other/TSA _____

Total Income _____



<i>Monthly Expenses</i>	<i>Amount</i>
Rent/Mortgage	
Utilities (Gas, Electric, Phone, Water)	
Food	
Medical/Medicine	
All Insurance Premiums	
Auto Loan Payments	
Other Loan Payments	
Child Support	
All Other	
Total Expenses	

<i>Assets</i>	<i>Name</i>	<i>Amount</i>
Savings		
Checking		
Stocks/Bonds - Cash Value		
Life Insurance - Cash Value		
All Other/TSA		
Total Assets		

<i>Property-Type</i>	<i>Year</i>	<i>Est. Value</i>	<i>Make/Model</i>
Home			
Business			
Auto/Truck			
Motorcycle			
All Other			
Totals			

I certify that the above information is true and complete. You are authorized to contact and obtain from any source verification of the above information or any other information you deem necessary relative to this application. Documentation is required with completed application. When no income is listed, please explain how you are meeting your day-to-day expenses in the remarks section.

Patient or Legal Representative _____ Date _____

Address (Business) _____

Interviewed By _____ Date _____

Remarks Section: _____

Please sign and fill out the application completely and send the following supporting documentation:

- 1: The current year tax returns (state and federal)*
- 2: A copy of your most current paycheck stub showing year to date gross earnings*
- 3: Current bank statements, if applicable*
- 4: Documentation of all bills*