Tomah Health
TOGETHER IN CARE

501 Gopher Drive
Tomah, WI 54660
(608)372-2181

FINANCIAL ASSISTANCE APPLICATION

Date: _____

PERSONAL INFORMATION

Patient's Name: _____Date of Birth: _____
Address (Street, City, State, and Zip code):_____
Phone (Home & Cell): _____Best Time To Call: _____
Responsible Party's Name: _____ Relationship to Patient: _____
Spouse's Name: _____Date of Birth: _____
List of Dependents Living in Household:

Name(s):	Age(s):

EMPLOYMENT INFORMATION

	Responsible Party/Guarantor	Spouse/Other Household Member
Occupation/Title:		
Employer Name:		
Employer Address:		
Employer Phone:		
Hourly Wage:		
Hours Worked Monthly:		
If unemployed, last date worked:		

SOURCE OF MONTHLY INCOME

	Responsible Party/Guarantor	Spouse/Other Household Member
Gross Monthly Employment Income:	$	$
Social Security:	$	$
Disability:	$	$
Pension:	$	$
Unemployment Benefits:	$	$
Child Support:	$	$
Alimony:	$	$
VA Benefits:	$	$
Other:	$	$

Tomah Health
TOGETHER IN CARE

501 Gopher Drive
Tomah, WI 54660
(608)372-2181

ASSETS

Bank Name:	Type of Account:	Latest Ending Statement Balance:
		$
		$
		$
		$

Auto/Truck Value	Amount Owed	Model	Year
1.			
2.			

List Any Other Assets (boats, ATVs, snowmobiles, etc):_____

LIABILITIES

	MONTHLY
Mortgage / Rent:	$
Auto (i.e., maintenance):	$
Utilities (i.e., electric, heat, phone, water, etc.):	$
Child Care / Child Support:	$
Medication Costs:	$
Bank Loans:	$
Other Debts (medical bills from other facilities):	$
TOTAL:	**$**

Please comment on any other items regarding your financial situation which you feel should be taken into consideration while determining your Financial Assistance eligibility:

_____

_____

I authorize Tomah Health to verify any information on this financial statement. I attest that the above information is true to the best of my knowledge and fully represents my current financial status. I understand that this application solely applies to accounts for services at Tomah Health.

Responsible Party (Guarantor): _____ Date: _____
(Signature)

FOR OFFICE USE ONLY

Adjudication:

Discount (if applicable): %	W/O Amount: $	Patient Balance: $
Patient Balance Payable as:		

PFS Counselor:	CEO/CFO approval if W/O > $10,000:

Additional Comments: