*****Please complete only if requesting financial assistance for services*****

Prevea Health Community Care

Prevea Health Community Care Program

Prevea Health Community Care Program is a program designed to assist our patients financially when they do not qualify for other financial assistance programs.

In order to be considered for the Prevea Health Community Care Program, please complete a Community Care Application and return it within 14 days. **Include copies of the following:**

- your most recent tax return
- your most recent pay stub
- disability or social security stub
- bank statement
- any denials from Medicaid or SSI
- any denials from other agencies or facilities you have requested financial assistance from.
- Copies of statements from monthly expenses

Prevea's Community Care staff will review your application and financial documentation, and contact you with a decision or recommendations within four weeks.

Although it is important to us to keep you as a patient, be aware that a complete elimination of your financial obligation to Prevea Health may result in our inability to continue care.

There are a number of other programs for which you or members of your household may be eligible. Please complete the attached Prevea Health Community Care Application, enabling Prevea Community Care staff to review your circumstances and determine your eligibility.

If you have questions about the Community Care program or the application process, please contact Prevea's Patient Advocate staff at (920) 405-1445. We will be happy to assist you.

Return Community Care Application to: Prevea Health
Attn: Cindy Tank
P.O. Box 19070
Green Bay, WI 54307-9070

Date Sent: ____________________
Date Returned: ________________
Account#: ____________________

Prevea Health Community Care

Application

Patient Name: ______________________________ **Patient Age:** ______ **Date of Birth:** ______________

Address: ____
Street City County State Zip

How long have you lived at this residence? _______________

Social Security Number:______________________________ **U.S. Citizen:** _____**Yes** _____ **No**

Home Phone: _______________ **Work Phone:**_______________ **Other Phone:** ______________

Have you or anyone in your household applied for Prevea Community Care in the past? _____**Yes** _____**No**

Name of previous applicant: ____

If applicant is a minor, list parents:
Mother: ________________ ____________ ____
Name Birth Date Address Phone

Father: ________________ ____________ ____________________________ ________________
Name Birth Date Address Phone

Marital Status of Parents: Single_______ Married_______ Widowed_______ Divorced_______

If applicant is an adult:
Marital Status: Single_______ Married_______ Widowed_______ Divorced_______

Spouse: ______________________ ____
Name Address Phone

________________ ____________ ________________ ________________
Date of Birth Age U.S. Citizen Non U.S. Citizen

Household Tax Dependents:

Name	Birth date	U.S. Citizen?	Name	Birth date	U.S. Citizen?
________________	________	Y/N	________________	________	Y/N
________________	________	Y/N	________________	________	Y/N
________________	________	Y/N	________________	________	Y/N
________________	________	Y/N	________________	________	Y/N
________________	________	Y/N	________________	________	Y/N

Prevea Health Community Care

Is anyone in the household pregnant? _______ **Yes** _________ **No**

If yes, complete the name of the person: ________________________________

Clinic/Doctor that verified the pregnancy: ______________________________ **Date of Test** _______________

Has this person applied for Medical Assistance? ________ **Yes** ________ **No**

Does the applicant currently have health insurance? _______ **Yes** _______ **No** _______ **Partial**

Does the applicant's spouse/children have health insurance? _______ **Yes** _______ **No** _______ **Partial**

Name of Insurance: ____
(group or private health insurance)

Insurance company's mailing address: ____

Policy Number: ____

Group Number: ____

If private insurance, note family burden: Deductible amount $_____________ Coinsurance amount _________ %

If no coverage, how long since last coverage? ____

Why was coverage lost?

_______ medical reasons
_______ changed jobs & lost coverage
_______ employer no longer offers insurance
_______ employer-offered policy too costly
_______ increase in income/assets
_______ private policy too expensive
_______ other: ___________________

Coverage held by family over the past two years:

_______ Medical Assistance
_______ Mixture of M.A. and private insurance
_______ private insurance
_______ none

Do you receive any public assistance benefits? If yes, please include a copy of your benefits card/notification.

Name of program	Family member covered	Caseworker	Phone
______________	______________	______________	______________

If accepted for public assistance, please provide numbers: ____

Please list the public assistance benefits for which you've recently applied.

Name of program	Date applied	Agency phone
______________	______________	______________

If denied for public assistance, why? ______________________________

Please note: If you have been denied for pubic assistance in the last two months, please include a copy of the denial. If you no longer have it, please contact the agency where you applied and ask for a copy.

If accepted for public assistance, please provide numbers: ______________________________

Is anyone in the family attending college?

_____ Yes, Name of school ____________________

_____ No

Is anyone in the family a veteran?

_____ Yes, Name ____________________

_____ No

Is anyone in the family disabled?

_____ Yes, Name ____________________

_____ No

Name of physician diagnosing disability: ______________________________

Please briefly describe the reason for applying to the Prevea Health Community Care Program. Please include details on any specific medical needs and financial concerns you are facing: ____________________

Medical Needs

Please complete the following questions to help us determine the nature of your present medical needs.

Applicant's Name: ____

Is your primary care provider with Prevea Health? _______Yes ______ No

Name of primary care provider: ______________________________

Please describe any recent diagnosis your physician has made and his/her suggestions for treatment:

____

____

____

____

____

____

Are you scheduled for additional treatment or visits at Prevea Health? _______ Yes _______ No

If yes, indicate dates: ____

Please indicate names of other physicians you have been referred to for evaluation or treatment:

Physician Name	Location

Financial Statement

Personal information of applicant or parent, if applicant is a minor

Name: ______________________ Social Security Number: ______________________

Address: ______________________

Telephone: ______________________

Employment information of applicant or parent, if applicant is a minor

Check employment status: ______employed ______unemployed ______other(explain) ______________________

Occupation: ______________________ Employer (if employed) ______________________

Address: ______________________

Telephone: ______________________ Length of Employment: ______________________

Monthly Gross Salary: ______________________ Monthly Net Salary: ______________________

Additional Sources of Income (per month):

Interest, Dividends	$ ________	Worker's Compensation	$ ________
Rental Income	$ ________	Unemployment Compensation	$ ________
Farm Income	$ ________	Food Share	$ ________
Self Employment	$ ________	SSI or SSDI	$ ________
Alimony	$ ________	Social Security Retirement	$ ________
Child Support	$ ________	Veteran's Benefits	$ ________
Pension	$ ________	Other (explain)	$ ________

Employment information of spouse, if applicable

Check employment status: ______employed ______unemployed ______other(explain) ______________________

Occupation: ______________________ Employer (if employed) ______________________

Address: ______________________

Telephone: ______________________ Length of Employment: ______________________

Monthly Gross Salary: ______________________ Monthly Net Salary: ______________________

Additional Sources of Income (per month):

Interest, Dividends	$ ________	Worker's Compensation	$ ________
Rental Income	$ ________	Unemployment Compensation	$ ________
Farm Income	$ ________	Food Share	$ ________
Self Employment	$ ________	SSI or SSDI	$ ________
Alimony	$ ________	Social Security Retirement	$ ________
Child Support	$ ________	Veteran's Benefits	$ ________
Pension	$ ________	Other (explain)	$ ________

Prevea Health Community Care

Monthly Expenses

Number of persons in household: ____________

Mortgage: $__________ or Rent: $ __________

Childcare: $ __________

Child Support Paid Monthly: $ __________

Heat & Utilities: $ __________

Assets

Cash in Bank:

Savings: $ __________

Checking: $ __________

CD's, Stocks, Bonds: $ __________

Auto:

Make/Type: ____________________

Year: ____________________

Cash on Hand $ __________

Assessed Value of Home: $ __________

Auto:

Make/Type: ____________________

Year: ____________________

Other Real Estate: $ __________

Other Assets (explain): $ __________ ____________________

Other Liabilities

Mortgage:

Balance: $ __________

Monthly Payment: $ __________

Home Equity Loan:

Balance: $ __________

Monthly Payment: $ __________

Credit Union Loan:

Balance: $ __________

Monthly Payment: $ __________

Second Mortgage:

Balance: $ __________

Monthly Payment: $ __________

Auto Loan:

Balance: $ __________

Monthly Payment: $ __________

Other Loan:

Balance: $ __________

Monthly Payment: $ __________

Charge Accounts Name	Balance	Monthly Payments	Credit Limit	**Medical Bills** Facility	Balance	Monthly Payments	Credit Limit

Do you have any medical bills involved in third party liability or workers compensation claims? _______ Yes _______No

The information received on financial statement is confidential and is for the review of your immediate situation.

I/We hereby certify the above information is correct and voluntarily authorized you to obtain or exchange credit information relative to me/us.

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________