BURNETT MEDICAL CENTER
HOSPITAL | NURSING HOME | CLINIC
257 W St George Ave
Grantsburg WI 54840
(715) 463-5353 or (800) 293-5353

Attachment E

Community Care Program Application

Please complete the application below. Please note that additional documentation may be requested to complete the review of your application. If approved, your application is valid for six (6) months. If you need help filling out this application, or have questions, please call our office.

Please list the people who live in your household.

First and Last Name	Date of Birth	Relationship to You	Does this person have Medical Assistance
1)		Self	
2)			
3)			
4)			
5)			
6)			

Required Information for ALL Household Members (If Applicable)		Send Copies Of:	Yearly Amount Gross)
Federal Tax Return		Last year's Federal Tax Return 1040 including schedule C, E, and/or F if applicable	$
Employment Income		Last 2 full months (60 days) of employment pay stubs	$
SSI, SSDI, RSDI Income		Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	$
Unemployment / Work Comp Benefits / Disability		Benefit Letter AND a copy of pay history	$
Child or Spousal Support		Benefit Letter AND a copy of 2 most recent bank statements showing deposits	$
Pension, Annuity, VA Benefits		Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	$
Other Income (Tribal, TANF, MFIP, etc.)		Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	$
Checking, Savings, Flex, HSA's, HRA, etc. *Flex/HSA/HRA accounts must have a balance less than $25.00		Last 2 months of bank statements for each type of account (not applicable for families with annual income at or below 200% of the current FPG).	
Medical Assistance Application		Award / Denial Letter from the County (not applicable for families with annual income at or below 200% of the current FPG).	
	Check here if you did not file taxes last year	Total Income: $	
	<u>No Income:</u> Please explain how you support yourself. For example: daily living expenses such as food, gas, housing and other bills.		
Other Property / Assets (not applicable for families with annual income at or below 200% of the current FPG).:		Send Copies Of:	Estimated Value:
	Other Property Owned (besides your primary home)	Last year's property tax statement for each property	$
	Retirement & Investment Accounts: IRAs, 401Ks, Stocks, Bonds, Life Insurance, Pension Plan, etc.	Most recent statement(s) for each account	$

I/we hereby request that Burnett Medical Center determine my eligibility for the Burnett Medical Center Community Care Program. I acknowledge that the information provided in this application is true and correct. I understand that the information that I submit will be subject to verification by Burnett Medical Center, and if this is determined to be false, it will result in a denial of the Burnett Medical Center Community Care Program. Failure to fully complete this application and provide supporting documents may result in a denial of the application.

Applicant's Signature: _____ Date: _____