Grant Regional Health Center's Community Responsibility Program (FAP) is available to patients to help them meet their financial obligations for medical expenses incurred at Grant Regional Health Center. A Community Responsibility application must be completed and submitted along with copies of the documents indicated below. **Please check all that apply and mail in the proper supporting documents**. If additional information is needed to make a decision regarding your Community Responsibility application; you will be notified so that it can be supplied as soon as possible and not hold up the process. Once all information has been received and reviewed by Grant Regional Health Center, a letter of decision will be sent informing you of the approval or denial of your application. The Community Responsibility process should be completed within 30 days depending on how quickly information is returned upon request.

( ) Denial from Wisconsin Medicaid for medical benefits
To apply for benefits (Online: access.wi.gov *or* Phone: 1-888-794-5780)

( ) Current W-2 and tax forms (copy of **2016** Tax Return)

( ) Last (3) paycheck stubs from employment

( ) Social Security Award Letter for the current year

( ) Unemployment Compensation Benefit Letter

( ) Copy of the last (2) monthly Checking Account Statements

( ) Copy of Saving Account Statement

( ) Copy of current mortgage statement

( ) Copy of most recent property tax bill

( ) Copy of credit card statements

( ) Rent Receipt or Lease

( ) Room and Board Letter

( ) Utility Bills

When application is complete and ALL supporting documentation is collected, please mail attn: Business Office in the enclosed envelope. If this has not been done within 30 days, we will assume you are not interested in the program & will continue with our collection process.

Grant Regional Health Center
507 South Monroe Street ♦ Lancaster, Wisconsin 53813
608-723-2143 (fax) 608-723-6997

Grant Regional Health Center

Community Responsibility Application (FAP)

Section I. Patient Information

Patient Name: _____ Today's Date: _____ Medical Record # _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Party: (Guarantor) _____ Relationship: _____

Other Household Members:	Relationship to applicant:
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

Total Number in Household: ☐

Section II. Income and Source

Note: Represents total cash receipts from all sources before taxes including wages, public assistance payments, social security, unemployment or worker's compensation benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance income, insurance or annuity payments, interest, rental income, royalties, estate or trust income, tax refunds and compensation for injury claims. Household income includes all income of patient, responsible party, spouse of responsible party and other immediate family members in the same household.

Source of Income:	Annual Amount	Relation to Patient	*Internal use only* Verified? Yes	No	Initials
Annual Income Total:					

Section III. Family Expenses

	Creditor	Monthly Payment	Balance Remaining	*Internal use only* Verified? Yes	No	Initials
Rent/Mortgage:						
Credit Union:						
Credit Card:						
Auto Loan:						
Utilities:						
Other:						
Total Expenses Per Month:						

Section IV. Family Assets

Type of Asset	Creditor	Market Value	Loan Value	Verified? Yes	No	Initials
Home:						
Cars:						
Checking:						
Savings:						
Credit Union:						
CD's:						
IRA's:						
Other:						

Section V. Authorization

I attest that information on this application is accurate to the best of my knowledge and accurately represents my current financial status. I authorize Grant Regional Health Center (GRHC) to verify any information offered on this application. I understand that this application is only valid for the dates of service approved by GRHC. If in the future, I, or one of my family should need further medical care at GRHC, I may be asked to supply updated information again. I authorize any financial institution listed on this application to release my financial information to GRHC to allow verification of my financial assets.

Patient or Guarantor _____ Date: _____ Witness _____ Date _____

Internal use only

Required Signatures for Approval:		Service Date(s) covered
Business Office Director/Date	*CFO /Date*	