COMMUNITY CARE APPLICATION

NAME:_____
First Middle Initial Last

ADDRESS:_____
Street City State ZIP Code

PHONE: (_____) _____

EMPLOYER:_____ OCCUPATION:_____

FAMILY INCOME (Please include proof of income**)	Self Total for Last 3 Months	Self Total for Last 12 Months	Spouse Total for Last 3 Months	Spouse Total for Last 12 Months
Wages				
Public Assistance/Disability				
Social Security				
Unemployment Compensation				
Workman's Compensation				
Alimony/Child Support Income				
Pension				
Income: Dividend/Interest/Rent				
Other:_____				
TOTAL				

ASSETS

Value of Checking/Savings_____
Value of Home_____
Value of Other Land_____
Year & Make of Auto_____
Year & Make of Auto_____
Value of Auto(s)_____
Other Assets: Please list with value (camper, boat, snowmobile, other)
_____
_____
_____
_____

DEBTS PER MONTH

Rent/Mortgage_____
Utilities (heat, electric, water only)_____
Other Loans_____
Car Payment_____
Car Payment_____
Child Support/Alimony Payment(s)_____
Monthly Out of Pocket Prescription Costs_____
_____
Other Medical Bills (please list with balance)_____
_____
_____

FAMILY SIZE (please list name and age of any person that can be claimed on your tax return)

_____ _____
_____ _____
_____ _____
_____ _____

I affirm that the above information is true and correct to the best of my knowledge. I also understand that if the information that I have submitted is determined to be false, such determination will result in a denial of this application and that I will be liable and be expected to pay for the services provided.

Signature:_____ Date:_____

**PROOF OF INCOME would include a copy of one or more of the following: most recent year's tax return, most recent year's W-2 forms, most recent paycheck stubs, or most recent bank statements for direct deposit. Please note, if you are self-employed, you must provide a COMPLETE copy of your prior year's tax return.