TURVILLE BAY
RADIATION ONCOLOGY CENTER
A member of SSMHealth

UNCOMPENSATED CARE PROGRAM APPLICATION

Requirements: 1. Complete this application within thirty (30) days of receipt.
2. Provide the following at the time your application is submitted:

a) A letter stating why you are requesting uncompensated care.
b) A signed copy of your most recent federal and state tax returns. (If no return was filed, send a signed statement explaining why no tax returns were filed.)

Return this completed application, including all requirements listed above, to the following address:

Turville Bay Radiation Oncology Center
Attention: Billing Department
1104 John Nolen Drive Madison, WI 53713

Please indicate the reduction that you are requesting on your total bill. $

Please indicate the amount that you could pay per month. $

PATIENT INFORMATION	
Name	Social Security #
Address	
Home Phone: ( )	Work Phone: ( )
Date of Service:	
Marital Status: Single Married Widowed Legally Separated Divorced Name of Spouse:	

Dependents	
Name	Age

FINANCIAL STATEMENT	
PERSON RESPONSIBLE FOR BILL (Guarantor)	(If different from patient/spouse listed above)
Name:	Social Security #:
Spouse:	Social Security #:
Home Phone: ( )	Number of Dependents:

INCOME	
Include all sources of income, including wages, unemployment compensation, sick pay, disability pay, worker's compensation, pension or retirement, social security (including SSD & SSI), rental income, dividends and interest.	
Income Source:	Monthly Income:
Spouse Income Source:	Monthly Income:
Other Sources of Income:	
If you have no source of income, how have you been supporting yourself?	

EMPLOYABILITY			
Are you (guarantor) currently working?	Yes No	Full Time	Part Time
If not, give the last date you were employed.			
Do you expect to resume full-time work?	When?		
Do you have the potential to work full-time:			
If not, give the reason.			
Is your spouse currently working?	Yes No	Full Time	Part Time
If not, give the last date your spouse was employed.			
Does your spouse expect to resume full-time work?			
Does your spouse have the potential to work full-time?			
If not, give the reason.			

MONTHLY EXPENSES		
	Monthly Payment	Outstanding Debt
Rent (or House Payment)		
Automobile Payment		
Utilities and Phone		
Other Medical Expenses (not covered by insurance)		
Childcare		
Other (please specify)		

ASSETS	
Checking Account(s): $	Stocks/Bonds/Certificates of Deposit: $
Savings Account(s): $	Life Insurance (Cash Value): $
Retirement Fund (Cash Value): $	Real Estate: $
Other Assets (please specify): $	

OTHER INFORMATION
Has you financial situation changed significantly since the filing of your tax return? If so, please explain:
Please indicate any additional factors not listed on this application that affect your ability to pay this bill:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Turville Bay Radiation Oncology Center to verify all income, expenses and assets listed in this application. I understand written notification is required by me to revoke this authorization. I also understand that a photocopy of this authorization has the same effect as the original.

I swear and affirm that the information provided in this application is true and complete to the best of my knowledge and belief.

Signature of Patient *Date*

If signed by person other than patient, state the relationship and authority to do so:

Patient is: _____Minor _____ Incompetent

Authority: _____ Legal _____ Legal guardian

FOR OFFICE USE ONLY:

Date received:_____ Date Reviewed:_____

Reviewer:_____

Action:_____