

**Anxiety Disorders Foundation**  
**P.O. Box 560**  
**Oconomowoc, WI 53066**

**Phone: 262-567-6600**  
**Fax: 262-567-7600**  
**www.anxietydisordersfoundation.org**

**REQUEST FOR DETERMINATION OF ELIGIBILITY FOR COMMUNITY CARE**

I request that The Anxiety Disorders Foundation make a written determination of my eligibility for community care for uncompensated outpatient services. I understand that the information that I submit concerning my annual income and family size is subject to verification by The Anxiety Disorders Foundation. I also understand that if the information that I submit is determined to be false, all granted community charity care will be rescinded and I will be liable for any balance due.

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
First Middle Last

**Address:** \_\_\_\_\_  
Number and Street City State Zip Code

**Telephone Number:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Number of Years at Present Address:** \_\_\_\_\_

**FAMILY SIZE**

**Spouses Name:** \_\_\_\_\_

Name	Age	Relationship

**HOSPITAL INSURANCE**

Name of Insurance Company/Group Plan	Policy Number

**INCOME**

	Patient/Guarantor	Spouse/Guarantor
<b>Employer</b>		
<b>Business Address</b>		
<b>City/State/Zip Code</b>		
<b>Wage Rate</b>	<b>Hr/Wk/Mo</b>	<b>Hr/Wk/Mo</b>
<b>Business Phone</b>		
<b>Occupation</b>		
<b>How Long Employed</b>		
<b>Social Security Number</b>		

List combined income for Guarantors (yourself, spouse and other dependents):

	Total for Last 3 Months	Total for Last 12 Months
Wages	\$	\$
Farm or Self-Employment		
Public Assistance		
Social Security		
Unemployment/Workman's Comp		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends/Interest		
Rent Income		
Others		
<b>TOTAL</b>	<b>\$</b>	<b>\$</b>

**ASSETS AND LIABILITIES**

Assets: Patient, Spouse and Other			Liabilities: Bills and Debt-Combined Family Members Combined		
Type	Location	Amount	Type	Location	Amount
Checking		\$	Credit Union		\$
Savings		\$	Bank Loans		\$
Credit Union		\$	Credit		\$
CD's		\$	Other		\$

**ASSETS – PROPERTY:**

Location: \_\_\_\_\_

Assessed Taxable Value \$ \_\_\_\_\_ Mortgage Balance \$ \_\_\_\_\_

**OTHER PROPERTY:**

Location: \_\_\_\_\_

Assessed Taxable Value \$ \_\_\_\_\_

**ASSETS – AUTO OR TRUCK:**

Make and Model: \_\_\_\_\_ Year: \_\_\_\_\_

Estimated Value \$ \_\_\_\_\_ Loan Balance \$ \_\_\_\_\_

Make and Model: \_\_\_\_\_ Year: \_\_\_\_\_

Estimated Value \$ \_\_\_\_\_ Loan Balance \$ \_\_\_\_\_

**OTHER ASSETS: Life Insurance, Bonds, Stocks, Boats, Etc.**

Description	Estimated Value	Loan Balance
	\$	\$

**REGULAR MONTHLY EXPENSES:**

Rent	\$	Alimony/Child Support	\$
Mortgage Payment	\$	Insurance Premiums	\$
Auto Loan Payments	\$	Utilities	\$
Other Loan Payments	\$	Other (Specify)	\$

I affirm that the above information, including income, is true and correct to the best of my knowledge. Further, I hereby give my permission to The Anxiety Disorders Foundation to disclose any information contained above to any Federal, Local or State agency responsible for determining The Anxiety Disorders Foundation uncompensated service compliance.

**I AUTHORIZE The Anxiety Disorders Foundation to verify any information given on this financial statement.**

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Patient or Responsible Party

Date