



Please return the signed application and supporting documents to:

Froedtert Health
Patient Financial Services
Attn: Financial Assistance Team
400 Woodland Prime Suite 103
N74 W12501 Leatherwood Ct
Menomonee Falls, WI 53051-4490
(800)466-9670

Please return the application and necessary paperwork within 10 days. Failure to return the completed application and all supporting documentation within 10 days may result in a denial of your application. Please send copies of the documentation. Do not send originals. If any of the supporting documents are unavailable, use the comment section to state why they are not included.

The following supporting documents must be submitted in order to process your application:

- If you are on Social Security Disability or over the age of 65, please include your T19 spend down eligibility date and dollar amount. If you have been denied by the T19 spend down program, please provide copy of denial.
- A copy of your most recent Federal Income Tax Return and W-2 forms. Include Schedule C tax forms if you and/or your spouse are self-employed.
- Proof of income. If married include your spouse's information, please submit two current pay stubs.
- A recent copy of your and/or your spouse's bank statement for every account on which either name appears.
- A recent copy of your and/or your spouse's statement for every investment including CD, stocks, bonds, and annuities.
- If you and/or your spouse are unemployed and receiving unemployment compensation, supply verification of unemployment benefits and the last pay stub from the previous employer.
- If you and/or your spouse are unemployed and supported by family or friends, please complete the attached "Income Attestation" form as verification of how you meet daily expenses.
- If you and/or your spouse are receiving worker's compensation payments, social security benefits, disability benefits, pension payments, alimony, child support, public assistance, or VA benefits, please submit verification of the benefit amount or a bank statement showing the direct deposit of income.



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Patient Information

Name _____
 Date of Birth _____
 Social Security Number _____
 Phone Number _____
 Address _____

Own Rent
 Other Property titled in your name? Yes No

Employer _____

Part Time: Full Time:
 Gross Earnings \$ _____ per
 Hr Wk Mo Yr (choose one)

If unemployed, last date of employment _____

Did you file federal income taxes last year?
 Yes No If yes, please include a complete copy.

Marital Status: Single Married Widowed Legally Separated Divorced

Spouse Information (If applicable)

Name _____
 Date of Birth _____
 Social Security Number _____
 Phone Number _____
 Address _____

Own Rent
 Other Property titled in your name? Yes No

Employer _____

Part Time: Full Time:
 Gross Earnings \$ _____ per
 Hr Wk Mo Yr (choose one)

Please list your and your spouse's income and assets below:

Patient

Income (monthly)

Social Security \$ _____
 Veterans Benefits \$ _____
 Workers Compensation \$ _____
 Unemployment \$ _____
 Interest/Dividends \$ _____
 Alimony \$ _____
 Child Support \$ _____
 Pension \$ _____
 Disability Income \$ _____
 Rental Property Income \$ _____
 Other Income \$ _____

Assets

Health Savings Account/Flex \$ _____
 Checking Account \$ _____
 Savings Account/Money Market \$ _____
 Stocks/Bonds/Annuities/Trusts \$ _____
 Certificate of Deposit \$ _____

Spouse (If applicable)

Income (monthly)

Social Security \$ _____
 Veterans Benefits \$ _____
 Workers Compensation \$ _____
 Unemployment \$ _____
 Interest/Dividends \$ _____
 Alimony \$ _____
 Child Support \$ _____
 Pension \$ _____
 Disability Income \$ _____
 Rental Property Income \$ _____
 Other Income \$ _____

Assets

Health Savings Account/Flex \$ _____
 Checking Account \$ _____
 Savings Account/Money Market \$ _____
 Stocks/Bonds/Annuities/Trusts \$ _____
 Certificate of Deposit \$ _____

Dependents. **Note:** Individuals over age 18 will not be considered dependents unless listed as a dependent on Income Taxes. (If you have more than 4 dependents, please attach a separate sheet.)

Name	Relationship	Date of Birth
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Accident Information (If your medical services are the result of an accident involving a 3rd party liability, please provide accident and insurance information):

Comments / Explanation of Circumstances:

I certify that the above information is complete and accurate. I hereby authorize Froedtert Health and the Medical College of Wisconsin to release any information necessary for verification of statements made on this application. Furthermore, I hereby authorize release of any information necessary to Froedtert Health and the Medical College of Wisconsin for the purpose of verification of statements on this application. This consent shall expire six (6) months from the date hereof. This consent is provided pursuant to Section 146.81, WI Stat.

Signed _____ Date _____

*Froedtert Health and the Medical College of Wisconsin reserve the right to deny any application if it is determined the information has been falsified, is incomplete, or for failure to apply or comply with other applicable assistance programs. All self-pay balances will then become patient due. If you receive a payment from a third party related to the medical charges, you agree to inform Froedtert Health and the Medical College of Wisconsin immediately and to pay the entire balance. Any discounts previously extended will be reversed. **This single application will be used to determine eligibility for Financial Assistance with both Froedtert Health and the Medical College of Wisconsin, but Froedtert Health and the Medical College of Wisconsin determine eligibility for financial assistance independently.** The Medical College of Wisconsin (MCW) determines your eligibility for financial assistance for all physician/professional fees as a separate decision. For assistance or questions regarding your MCW billing please call (414)-955-4511 or Toll Free (800)-242-1649. Froedtert Health determines your eligibility for financial assistance for all facility and ancillary services. For assistance or questions regarding your Froedtert Health billing please call Patient Financial Services at (414)-805-5951 or Toll Free (800)-466-9670.*



Income Attestation Section

If you and/or your spouse are supported by family or friends, please complete this section of the application as verification of how you meet daily expenses.

This section should be completed by either the patient, who must have their signature notarized, OR completed by the person who is helping support the patient either by providing room and board or giving money to pay daily living expenses.

Patient Name _____

Patient Social Security Number _____

Person providing support

- If you are filling out this section because you provide support to the patient, signing this section does not make you legally responsible for paying medical bills for this patient.
- A copy of a current photo ID for the individual providing support must be attached.

I, _____ attest to the fact
(Name of person providing support)

I currently contribute \$_____ on a monthly basis for the
day-to-day living expenses for _____
(Patient's name)

Signature _____ Date _____
(Signature of person providing support)

OR

Patient

- Signature of the patient **MUST** be notarized.
- A copy of a current photo ID must be attached.

I am supported by friends or family for day to day living expenses.

I receive \$ _____ each month

Patient Signature _____ Date _____

Notarized by _____ Date _____