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
Phone: (800)466-9670
Fax: (414) 777-1503
financial.assistance@froedtert.com

Please return the application and necessary paperwork as soon as possible.
Failure to return the completed application and all supporting documentation may result in a denial of your application. Please send copies of the documentation; they will be scanned and shredded. Do not send originals. Documents not needed will be shredded. 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 Medicaid deductible eligibility date and dollar amount. If you have been denied by the Medicaid deductible program, please provide a copy of denial.
- A copy of your most recent Federal Income Tax Return and W-2 forms, Schedule C tax forms if you and/or your spouse are self-employed, and any additional tax schedules filed.
- Proof of income. If married include your spouse's information, please submit one month of current pay stubs.
- A recent copy of the complete bank statement for every account on which your and/or your spouse's name appears; including direct deposit debit cards. A summary will not be accepted.
- A recent copy of your and/or your spouse's statement for every investment including certificates of deposit (CD), stocks, bonds, annuities, and trusts.
- If you and/or your spouse are unemployed and receiving unemployment compensation, supply verification of unemployment benefits.
- If you and/or your spouse are unemployed and supported by family or friends, whether monetary or room and board, 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 _________

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)

Did you file federal income taxes last year?
Yes☐ No☐ If yes, please include a complete copy. If no, last date filed _________
Marital Status: Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced ☐

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

Patient		**Spouse (If applicable)**	
Income (monthly)		**Income (monthly)**	
Social Security	$__________	Social Security	$__________
Veterans Benefits	$__________	Veterans Benefits	$__________
Workers Compensation	$__________	Workers Compensation	$__________
Unemployment	$__________	Unemployment	$__________
Interest/Dividends	$__________	Interest/Dividends	$__________
Alimony/Child Support	$__________	Alimony/Child Support	$__________
Pension	$__________	Pension	$__________
Disability Income	$__________	Disability Income	$__________
Rental Property Income	$__________	Rental Property Income	$__________
Other Income	$__________	Other Income	$__________
Assets		**Assets**	
Checking Account	$__________	Checking Account	$__________
Savings Account/Money Market	$__________	Savings Account/Money Market	$__________
Stocks/Bonds/Annuities/Trusts	$__________	Stocks/Bonds/Annuities/Trusts	$__________
Certificate of Deposit	$__________	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.*** *For assistance or questions regarding your bill, please call Froedtert and the Medical College of Wisconsin at (414) 805-5951 or Toll Free (800) 466-9670.*

Income Verification 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____________________