



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 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 T19 spend down eligibility date and dollar amount. If you have been denied by the T19 spend down 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 \_\_\_\_\_

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

**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**

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**

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 3<sup>rd</sup> 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 \_\_\_\_\_