INS-STC-FS-255

Froedtert | South

FINANCIAL ASSISTANCE APPLICATION

PLEASE READ CAREFULLY! In order for us to process your application for assistance, proof of income must be attached.

Please note: Any blank spaces may disqualify or delay processing of your application.
Complete this form in ink.

Please attach the following required documents:

☒ Filed Tax Return (Federal, State and W2s) - Year to be specified by Financial Counselor
☒ Letter of Financial Situation ☒ Picture I.D.

Please mail the completed form to: Froedtert Kenosha Clinic 6308 Eighth Avenue Kenosha, WI 53143-5082

Contact Name: Phone Number:

Date: Account Number(s):

Patient's Name: Patient's Date of Birth:

Address:

City, State, Zip Code:

SSN:

Marital Status: ❑ single ❑ married ❑ widowed ❑ divorced ❑ separated

Spouse's Name: Spouse's Date of Birth:

Number of Dependents: _____

Dependent's Name: Date of Birth:

Dependent's Name: Date of Birth:

Dependent's Name: Date of Birth:

Dependent's Name: Date of Birth:

Dependent's Name: Date of Birth:

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETE)

Are you currently employed? ❑ Yes ❑ No Are you self-employed? ❑ Yes ❑ No

Patient or Parent		Spouse or Parent	
Current or Last Employer		Current or Last Employer	
Street Address	Telephone #	Street Address	Telephone #
City	State Zip	City	State Zip
Supervisor's Name	Telephone #	Supervisor's Name	Telephone #
Monthly Net Income		Monthly Net Income	
Employment Dates: From_____ To: _____ (Require previous employment information if short term)		Employment Dates: From_____ To: _____ (Require previous employment information if short term)	

OTHER SOURCES OF INCOME (check type and list amount):

❑ Alimony / Child Support _____ ❑ Pension Annuity _____ ❑ Social Security _____

❑ Workmen's Compensation _____ ❑ Veterans Pension _____ ❑ Rental Income _____

❑ Unemployment Compensation _____

❑ Other _____

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to Froedtert South for verification of this financial statement.

_____ _____

Signature of Patient / Parent / Spouse Date

_____ _____

Froedtert South Provider Representative Date