

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

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