

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: _____

