

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:

- Latest Tax Return Filed (Federal, State and W2s)
- Letter of Financial Situation Picture I.D.

Please mail the completed form to: Froedtert South 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

******* A copy of your current tax return must accompany this form.**