

Financial Assistance Application

UW Health - Financial Assistance 877-278-6437 PO Box 620993 Middleton, WI 53562

Applicant Name (First, Middle, Last)		Date			Medical Re	cord # (If K	(nown)
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 To apply for Financial Assistance, please include This Application, signed and dated Federal tax returns and supporting schedules (here) Pay stubs or other income verification (last more) From which organizations are you applying 	 Benefit Last 2 r (If no ii 	award letters nonths full ba ncome) Letter	nto will not be sha (pension, unemplo nk statements (or i explaining how yo LTH - WI & IL F	oymen ndicat ou are 1	t, SSI, SSDI) e you don't hay meeting your c	ve bank acco	
Does the patient currently have insurance c		No					
Coverage:							
If not, has the patient applied for coverage t		hcare.gov)?				Yes	No
Does the patient participate in a Health Sha	ring Ministry Product?					Yes 🗆] No
Does the patient elect to not participate in a	government funded insurance	program fo	r religious/cultur	al rea	sons?	Yes 🗆] No
Did the patient/financially responsible part If not, why?	y file taxes last year?	□ Yes	□ No				
Patient/Financially Responsible							
Name (First, Middle, Last)		Relationsh	nip to Patient	I	Birth Date (M	lonth DD, YY	YY)
Address		City		State	e	ZIP Code	
Phone	Household Size (Patient, Spouse and Dependents) Marital S		ital Status				
Employment Status			If unemploy	yed, la	ast day/mont	h & year w	orked
🗆 Full Time 🛛 Part Time 🔲 Self Emplo	yed 🗌 Retired 🔲 Student] Unemplo	yed				
Employer			Weekly Income Employment Date (Month DD, YY Hrs/Week: Pay(\$)/Hour:		YYYY)		
Spouse/Partner		·					
Name (First, Middle, Last)		Birth Date	(Month DD, YY	YYY)	Phone		
Address		City		State	2	ZIP Code	
Employment Status			· · ·	ved, la	st day/mont	h & year w	orked
🗆 Full Time 🔲 Part Time 🔲 Self Emplo	yed 🗌 Retired 🔲 Student	🗌 Unemplo	yed				

Dependents

Employer

Full Name	Relati	tionship	Birth Date (Month DD, YYYY)
1.			
2.			
3.			
4.			

Weekly Income

Hrs/Week: Pay(\$)/Hour: Employment Date (Month DD, YYYY)

Monthly Income of Financially Responsible Party and Spouse (if applicable)

Patient/Responsible Party	Spouse	
Monthly Social Security Income	Monthly Social Security Income	
Date of SSDI Application	Date of SSDI Application	
Pension	Pension	
Unemployment	Unemployment	
Cert of Dep/IRA	Cert of Dep/IRA	
401K Withdrawal	401K Withdrawal	
Rental/Property Income	Rental/Property Income	
Other Income	Other Income	

Other Medical Bills Owed (Not at UW Health or Meriter)

Туре	List Name/Use for Loans/Credit Cards	Unpaid Balance	Monthly Payment

Assets >\$10,000

List any liquid assets you have with a value over \$10,000. Do not include your primary home, primary vehicle, or retirement/college savings accounts.

Other Comments

Optional Additional Info (Choosing to answer these questions will not impact your application)

Race:		America In	idian or Alaska	Native 🗆 Asian	\Box Black or African American	□ Native Hawaiian or Other Pacific Islander
		White/Cau	Icasian	□ Other	□ Decline to Answer	
Ethnicity:		Hispanic/I	Latino 🗆 Not	Hispanic/Latino	\Box Decline to Answer	
<u>Sex</u> :		Male	□ Female	\Box Nonbinary	\Box Decline to Answer	
Preferred I	Lang	uage:				

Certification

I understand this information will be used only for determination of financial responsibility for my charges at UW Health and will be kept confidential. As part of the Financial Assistance program requirements, I am required to be screened for Medicaid or other public assistance programs, including but not limited to the following: BadgerCare – WI Medicaid; Elderly, Blind, Disabled (EBD); Alien Emergency Medical Assistance (AEMA); Victim of Violent Crime Compensation Fund (VOVC); Presumptive Disability/Medicaid; Social Security Disability/Income (SSD/SSI); Marketplace Health Insurance. My signature authorizes the UW Health to verify any and all information furnished on this form.

If you have questions or concerns, please contact UW Health Customer Service (877-278-6437)

To sign document electronically: Go to "Tools" --> "Fill & Sign"

Patient/Responsible Party Signature	Date (Month DD, YYYY)
Name of person completing form if different from patient	Date (Month DD, YYYY)

Complaints or concerns with the uninsured patient discount application or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at: 1-877-305-5145 or https://illinoisattorneygeneral.gov/consumers/healthcare.html