UW Health | UnityPoint Health Meriter

Reset Form

Financial Assistance Application

UW Health
7974 UW Health Ct
Middleton, WI 53562

877-278-6437
*

Applicant Name *(First, Middle, Last)*	Date	Medical Record # (If Known)

For evaluation for the Financial Assistance Program, please include all the following items, as applicable:

- This Application, signed and dated
- Federal tax returns and supporting schedules (last years)
- Pay stubs (last months)
- Benefit award letters (pension, unemployment, SSI, SSDI)
- 2 Bank statements
- Letter explaining how you are meeting your daily living expenses

From which organizations are you applying for financial assistance? ☐ UW HEALTH ☐ MERITER ☐ BOTH

Does the patient currently have insurance coverage? ☐ Yes ☐ No

Coverage: _____

If not, has the patient applied for coverage through the Marketplace (Healthcare.gov)? ☐ Yes ☐ No

Does the patient participate in a Health Sharing Ministry Product? ☐ Yes ☐ No

Does the patient elect to not participate in a government funded insurance program for religious/cultural reasons? ☐ Yes ☐ No

Did the patient/financially responsible party file taxes last year? ☐ Yes ☐ No

If not, why? _____

Patient/Financially Responsible Party

Name *(First, Middle, Last)*	Relationship to Patient	Birth Date *(Month DD, YYYY)*	
Address	City	State	ZIP Code
Phone	Household Size (Patient, Spouse and Dependents)	Marital Status	
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed		If unemployed, last day/month & year worked	
Employer	Weekly Income Hrs/Week: Pay($)/Hour:	Employment Date *(Month DD, YYYY)*	

Spouse/Partner

Name *(First, Middle, Last)*	Birth Date (Month DD, YYYY)	Phone	
Address	City	State	ZIP Code
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed		If unemployed, last day/month & year worked	
Employer	Weekly Income Hrs/Week: Pay($)/Hour:	Employment Date *(Month DD, YYYY)*	

Dependents

Full Name	**Relationship**	**Birth Date** *(Month DD, YYYY)*
1.		
2.		
3.		
4.		

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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 Bills Owed (Medical Bills, Bank Loans, Credit Cards, Other)

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

Other Comments

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.

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)*