Today's Date (MM/DD/YYYY) (To be returned within 30 days)	
Medical Record #:	
Guarantor #:	
Referred By:	

Applicants Name (*First, Middle, Last)*

GUNDERSEN HEALTH SYSTEM®

FINANCIAL ASSISTANCE APPLICATION

Send to: Gundersen Health System, Attn: CFS/NCA3-01
1900 South Ave., La Crosse, WI 54601

Health Insurance If yes, please provide information and copy of insurance card	
Insurance Co Name and Address:	Policy Number:

Service Location	
☐ Gundersen Lutheran Medical Center/Clinics	☐ Gundersen St. Joseph's Hospital and Clinics
☐ Gundersen Boscobel Area Hospital and Clinics	☐ Gundersen Tri-County Hospital and Clinics
☐ Gundersen Palmer Lutheran Hospital and Clinics	☐ Other

Please check all boxes below that apply and provide supporting documentation	
☐ Medicaid Eligible, but not for date of service or for non-covered service	☐ Deceased with no estate
☐ Homeless – Explain:	☐ Incarceration in penal institution

INSTRUCTIONS: Complete application and attach copies of the following	
☐ 401K/Retirement/CD/etc. Statements	☐ Submit a letter describing your financial situation
☐ Pay stubs for 60 Days for all income reported	☐ Social Security Benefits (if applicable)
☐ Unemployment statements for 60 days	☐ Checking and savings bank statement
☐ Property tax statement	☐ Mortgage balance statement
☐ Current Federal Tax returns and supporting schedules To request a copy of your taxes, please call 1-800-829-1040	☐ If you did not file taxes, please explain why in a letter

I have applied for or will apply for federal or state medical assistance ☐ Yes ☐ No – If no, reason:
I have a lawsuit, settlement, personal injury, work comp or liability claims pending ☐ Yes ☐ No

Email Preference:	
I understand that unencrypted email is not a secure form of communication and that there is some risk that the information contained in emails may be misdirected, accessed, or intercepted by unauthorized third parties. I request that Gundersen Health System communicate information related to this Financial Assistance Application with me via email. I understand that I can revoke this request at any time.	☐ Yes ☐ No
Email Address:	

PATIENT/RESPONSIBLE PARTY			
Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/DD/YYYY)*	
Street Address	City	State	Zip Code
Phone	Household Size *(Patient, Spouse & Dependents)*		Marital Status
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student	Employer Name and Address		
Hire Date: *(MM/DD/YYYY)*	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐Yes ☐No If yes, provide tax return of those being claimed	
Unemployed: *(MM/DD/YYYY)* From: To:			

SPOUSE (If applicable)		
Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/DD/YYYY)*
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student	Employer Name and Address	
Hire Date: *(MM/DD/YYYY)*	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐Yes ☐No If yes, provide tax return of those being claimed
Unemployed: *(MM/DD/YYYY)* From: To:		

DEPENDENTS (If more than 4 dependents use a separate page)				
Full Name	**Relationship**	**Birth Date *(MM/DD/YYYY)***	**Claimed as a Dependent on Taxes**	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No
4.			☐ Yes	☐ No

OTHER MONTHLY INCOME					
Other Wages	$	Rental Income	$	Alimony/Child Support	$
Pension	$	Workers Comp	$	Unemployment	$
Misc. Income	$	Veterans Benefits	$	Interest/Dividends	$
Short or Long Term Disability		$	(SSI/SSDI) Social Security		$

PROPERTY			
TYPE	**MONTHLY PAYMENT**	**ESTIMATED VALUE**	**UNPAID BALANCE**
Primary Home	$	$	$
2nd Mortgage	$	$	$
Secondary/Vacation Home	$	$	$
Rental Property	$	$	$
Land	$	$	$

AUTO/MOTORCYCLE/RECREATIONAL VEHICLES			
TYPE/MAKE/MODEL/YEAR	**MONTHLY PAYMENT**	**ESTIMATED VALUE**	**UNPAID BALANCE**
	$	$	$
	$	$	$
	$	$	$
	$	$	$

ASSETS			
Checking Balance	$	Savings Balance	$
Stocks/Bonds	$	CD	$
401K	$	IRA	$
403B	$	Other/HSA/FSA	$

CERTIFICATION: I certify the preceding income/expense information is true and correct. Please be aware we may review the information you provided in conjunction with your credit report. I understand if I knowingly provide untrue information in the application, I will be ineligible for financial assistance and the financial assistance granted to me may be reversed and I will be responsible for the medical bills.

Patient/Responsible Party Signature	Date
Spouse (If applicable)	Date