

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



FINANCIAL ASSISTANCE APPLICATION

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

Applicants Name <i>(First, Middle, Last)</i>
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HEALTH INSURANCE <small>If yes, please provide information and copy of insurance card</small>	
Insurance Co Name and Address:	Policy Number:

SERVICE LOCATION	
<input type="checkbox"/> Gundersen Lutheran Medical Center/Clinics	<input type="checkbox"/> Gundersen St. Joseph's Hospital and Clinics
<input type="checkbox"/> Gundersen Boscobel Area Hospital and Clinics	<input type="checkbox"/> Gundersen Tri-County Hospital and Clinics
<input type="checkbox"/> Gundersen Palmer Lutheran Hospital and Clinics	<input type="checkbox"/> Gundersen Moundview Hospital and Clinics

PLEASE CHECK ALL BOXES BELOW THAT APPLY AND PROVIDE SUPPORTING DOCUMENTATION	
<input type="checkbox"/> Medicaid Eligible, but not for date of service or for non-covered service	<input type="checkbox"/> Deceased with no estate
<input type="checkbox"/> Homeless – Explain:	<input type="checkbox"/> Incarceration in penal institution

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION	
<input type="checkbox"/> Copies of 401K/Retirement/CD/etc. Statements	<input type="checkbox"/> Submit a letter describing your financial situation
<input type="checkbox"/> Copies of pay stubs for 60 Days for all income reported	<input type="checkbox"/> Copies of Social Security Benefits (if applicable)
<input type="checkbox"/> Copies of unemployment statements for 60 days	<input type="checkbox"/> Copies of checking and savings bank statement(s)
<input type="checkbox"/> Copies of property tax statement	<input type="checkbox"/> Copies of mortgage balance statement
Filed Federal income taxes? <small>To request a copy of your taxes, please call 1-800-829-1040</small>	
Yes – Please send the most recent Federal income tax returns and supporting schedules.	
No – Please explain why:	

I have applied for or will apply for federal or state medical assistance <small>(Not applicable to families with annual income at or below 200% of the current FPG)</small>
Yes No – Not a citizen No – Over income No – Other reason, why?

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			
Please check one: Single Married Widowed Divorced Separated			
Name <i>(First, Middle, Last)</i>	Social Security Number	Birth Date <i>(MM/DD/YYYY)</i>	
Street Address	City	State	Zip Code
Phone Number:	Household Size <i>(Patient, Spouse & Dependents)</i>		
Employment Status: Full Time Part Time Self Employed Unemployed Student Retired	Employer Name and Address		
Hire Date: <i>(MM/DD/YYYY)</i>	Position:	How Often Paid: Weekly Bi-Weekly Monthly Bi-Monthly	Are you claimed on another tax return? Yes No <small>If yes, provide tax return of those claiming you.</small>
Unemployed: <i>(MM/DD/YYYY)</i> From: To:	Average Gross Monthly Income: \$	Monthly SSI/SSDI: \$	

SPOUSE (If applicable)				
Name (First, Middle, Last)		Social Security Number	Birth Date (MM/DD/YYYY)	Phone Number:
Employment Status: Full Time Part Time Self Employed Unemployed Student Retired		Employer Name, Address, and Phone Number:		
Hire Date: (MM/DD/YYYY)	Position:	How Often Paid: Weekly Bi-Weekly Monthly Bi-Monthly	Are you claimed on another tax return? Yes No <small>If yes, provide tax return of those claiming you.</small>	
Unemployed: (MM/DD/YYYY) From: To:		Average Gross Monthly Income: \$	Monthly SSI/SSDI: \$	

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 (Please attach copies of your documents to support this income)					
Other Wages	\$	Rental Income	\$	Alimony/Child Support	\$
Pension	\$	Disability Income	\$	Unemployment	\$
Misc. Income	\$	Veterans Benefits	\$	Interest/Dividends	\$

PRIMARY EXPENSES: (Not applicable to families with annual income at or below 200% of the current FPG)			
TYPE	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
Rental Payment	\$	N/A	N/A
Primary Home	\$	\$	\$
2 nd Mortgage	\$	\$	\$
Secondary/Vacation Home/Land	\$	\$	\$
<input type="checkbox"/> None – Please explain why you have no rent or mortgage:			

AUTO/MOTORCYCLE/RECREATIONAL VEHICLES: (Not applicable to families with annual income at or below 200% of the current FPG)			
TYPE/MAKE/MODEL/YEAR	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

ASSETS: (Not applicable to families with annual income at or below 200% of the current FPG)			
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.

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED	
Patient/Responsible Party Signature	Date
Spouse (If applicable)	Date