Financial Assistance Application

Please complete and return to:

Agnesian HealthCare, Attn: Community Care, 430 E. Division Street Fond du Lac, WI 54935
(920) 926-4841

Referred by: ______________________ Today's Date: ____________ Date Due: ____________

Patient Name: ______________________

(PLEASE PRINT - BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

Name: ______________________

Street Address: ______________________ Home Phone: ______________________

City, State, Zip Code: ______________________ ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Single

County: ______________________ Spouse Name: ______________________

Date of Birth: ______________________ Spouse Date of Birth: ______________________

Social Security Number: ______________________ Spouse Social Security Number: ______________________

Health Insurance: ______________________ Health Insurance: ______________________

Monthly Premium: ______________________ Monthly Premium: ______________________

Does your employer offer health insurance? ❑ Yes ❑ No
Are you eligible? ❑ Yes ❑ No
Are you opting out of health insurance? ❑ Yes ❑ No

Does your employer offer health insurance? ❑ Yes ❑ No
Are you eligible? ❑ Yes ❑ No
Are you opting out of health insurance? ❑ Yes ❑ No

List of dependents living with you

Name:	Birthday (month/day/year):	Relationship:

Employment Information of Applicants

Primary Applicant: ______________________ Spouse: ______________________

Employer: ______________________ Employer: ______________________

City/State: ______________________ City/State: ______________________

Phone: ______________________ Phone: ______________________

Hire Date: ______________________ Hire Date: ______________________

Occupation: ______________________ Occupation: ______________________

Gross Monthly Salary: ______________________ Gross Monthly Salary: ______________________

Reason for Application: ______________________

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(over)

Primary Applicants Additional Source of Income

$ ______________ Interest, Dividends
$ ______________ Rental Income
$ ______________ Food Share
$ ______________ Alimony/Child Support
$ ______________ Pension
$ ______________ Worker's Compensation
$ ______________ Unemployment
$ ______________ Farm/Self Employment
$ ______________ SSI/Social Security
$ ______________ Veterans Benefits
$ ______________ Other Wages

Spouse Additional Source of Income

$ ______________ Interest, Dividends
$ ______________ Rental Income
$ ______________ Food Share
$ ______________ Alimony/Child Support
$ ______________ Pension
$ ______________ Worker's Compensation
$ ______________ Unemployment
$ ______________ Farm/Self Employment
$ ______________ SSI/Social Security
$ ______________ Veterans Benefits
$ ______________ Other Wages

Assets

$ ______________ Checking/Debit Balance
$ ______________ Stocks
$ ______________ Bonds
$ ______________ IRA
$ ______________ Savings Balance
$ ______________ CD
$ ______________ 401K
$ ______________ Other Assets/HSA/FSA

If you list additional income and assets above, provide written verification of that income for the past 30 days.

Property

Residence: ❑ Rent $ ___________ ❑ Own $ ___________ If no mortgage or rent explain why: __________________________

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I certify that the preceding income/expense information is true and correct.
Please be aware we may review the information you have provided in conjunction with your credit report for verification of debts listed.

Signature - Applicant: ________________________________ Signature - Spouse: ________________________________

Date: ________________________________ Date: ________________________________

Release of Financial/Medical Information

I, ____ , authorize the Agnesian HealthCare Financial Assistance programs to obtain any financial information held by the Social Security Administration, County Social Services, lending institutions, employers and insurance companies on myself, for the purposes of determining eligibility for financial assistance or Samaritan Health Clinic funding. This authorization will remain valid for a period of six months from my dated signature or may be revoked by myself at any time, (except to the extent that Agnesian HealthCare has already acted in reliance on it). I understand that a photocopy of this consent is as valid as the original. I hereby certify that the information on this application is correct.

I further authorize the release of any medical information regarding my care and treatment to any hospital, physician or other health care providers in connection with my continued care subsequent to this treatment. I understand the specific type of information to be disclosed includes diagnosis and treatment for physical illness, and where applicable, emotional illness, alcohol or drug abuse.

Signature - Applicant: ____ Date: ____________________

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Office Use Only

Community Care Approval Date: ________________ Discount Percent: ________________

Denial Date: ________________