EXHIBIT B – FINANCIAL ASSISTANCE APPLICATION

Please return the signed application and supporting documents to:
Froedtert Health Patient Financial Services
Attn: Financial Assistance Team
400 Woodland Prime Suite 103
N74 W12501 Leatherwood Ct
Menomonee Falls, WI 53051-4490
Phone: (800)803-8155
Fax: (414) 777-1503
financial.assistance@froedtert.com

Please return the application and necessary paperwork as soon as possible.

Failure to return the completed application and all supporting documentation may result in a denial of your application. Please send copies of the documentation; they will be scanned and shredded. Do not send originals. Documents not needed will be shredded. If any of the supporting documents are unavailable, use the comment section to state why they are not included.

The following supporting documents must be submitted in order to process your application:

- If you are on Social Security Disability or over the age of 65, please include your Medicaid deductible eligibility date and dollar amount. If you have been denied by the Medicaid deductible program, please provide a copy of denial.
- A copy of your most recent Federal Income Tax Return and W-2 forms, Schedule C tax forms if you and/or your spouse are self-employed, and any additional tax schedules filed.
- Proof of income. If married include your spouse's information, please submit one month of current pay stubs.
- A recent copy of the complete bank statement for every account on which your and/or your spouse's name appears; including direct deposit debit cards. A summary will not be accepted.
- A recent copy of your and/or your spouse's statement for every investment including certificates of deposit (CD), stocks, bonds, annuities, and trusts.
- If you and/or your spouse are unemployed and receiving unemployment compensation, supply verification of unemployment benefits.
- If you and/or your spouse are unemployed and supported by family or friends, whether monetary or room and board, please complete the attached "Income Attestation" form as verification of how you meet daily expenses.
- If you and/or your spouse are receiving worker's compensation payments, social security benefits, disability benefits, pension payments, alimony, child support, public assistance, or VA benefits, please submit verification of the benefit amount or a bank statement showing the direct deposit of income.

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Patient Information

Name _____
Date of Birth _____
Social Security Number_____
Phone Number_____
Address _____
_____
Own ☐ Rent ☐
Other Property titled in your name? Yes ☐ No ☐
Employer_____
Part Time: ☐ Full Time: ☐
Gross Earnings $_____ per
Hr☐ Wk☐ Mo☐ Yr☐ (choose one)

Spouse Information (If applicable)

Name _____
Date of Birth_____
Social Security Number _____
Phone Number_____
Address_____
_____
Own ☐ Rent ☐
Other Property titled in your name? Yes ☐ No ☐
Employer_____
Part Time: ☐ Full Time: ☐
Gross Earnings $_____ per
Hr☐ Wk☐ Mo☐ Yr☐ (choose one)

If unemployed, last date of employment _____
Did you file federal income taxes last year?
Yes☐ No☐ If yes, please include a complete copy. If no, last date filed _____
Marital Status: Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced ☐

Please list your and your spouse's income and assets below:

Patient		**Spouse (If applicable)**	
Income (monthly)		**Income (monthly)**	
Social Security	$_____	Social Security	$_____
Veterans Benefits	$_____	Veterans Benefits	$_____
Workers Compensation	$_____	Workers Compensation	$_____
Unemployment	$_____	Unemployment	$_____
Interest/Dividends	$_____	Interest/Dividends	$_____
Alimony/Child Support	$_____	Alimony/Child Support	$_____
Pension	$_____	Pension	$_____
Disability Income	$_____	Disability Income	$_____
Rental Property Income	$_____	Rental Property Income	$_____
Other Income	$_____	Other Income	$_____
Assets		**Assets**	
Checking Account	$_____	Checking Account	$_____
Savings Account/Money Market	$_____	Savings Account/Money Market	$_____
Stocks/Bonds/Annuities/Trusts	$_____	Stocks/Bonds/Annuities/Trusts	$_____
Certificate of Deposit	$_____	Certificate of Deposit	$_____

Dependents. **Note:** Individuals over age 18 will not be considered dependents unless listed as a dependent on Income Taxes. (If you have more than 4 dependents, please attach a separate sheet.)

Name	**Relationship**	**Date of Birth**
1.		
2.		
3.		
4.		

Accident Information (If your medical services are the result of an accident involving a 3rd party liability, please provide accident and insurance information):

Comments / Explanation of Circumstances:

I certify that the above information is complete and accurate. I hereby authorize Froedtert Health and the Medical College of Wisconsin to release any information necessary for verification of statements made on this application. Furthermore, I hereby authorize release of any information necessary to Froedtert Health and the Medical College of Wisconsin for the purpose of verification of statements on this application. This consent shall expire six (6) months from the date hereof. This consent is provided pursuant to Section 146.81, WI Stat.

Signed_____ Date_____

Froedtert Health and the Medical College of Wisconsin reserve the right to deny any application if it is determined the information has been falsified, is incomplete, or for failure to apply or comply with other applicable assistance programs. All self-pay balances will then become patient due. If you receive a payment from a third party related to the medical charges, you agree to inform Froedtert Health and the Medical College of Wisconsin immediately and to pay the entire balance. Any discounts previously extended will be reversed. ***This single application will be used to determine eligibility for Financial Assistance with both Froedtert Health and the Medical College of Wisconsin.*** *For assistance or questions regarding your bill, please call Froedtert and the Medical College of Wisconsin at (800) 803-8155.*