AGNESIAN HEALTHCARE
A member of SSMHealth

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/Cell: _____

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:	Insurance:

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: _____

_____

_____

_____

(over)

If you list additional income and assets below, provide written verification of that income for the past 30 days.
ALL BLANKS BELOW NEED TO BE FILLED IN WITH A DOLLAR AMOUNT OR ZERO.

Additional Source of Income	Primary Applicant	Spouse	Joint Account
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	**Primary Applicant**	**Spouse**	**Joint Account**
Checking/Debit Balance	$ _____	$ _____	$ _____
Savings Balance	$ _____	$ _____	$ _____
Stocks	$ _____	$ _____	$ _____
Bonds	$ _____	$ _____	$ _____
IRA	$ _____	$ _____	$ _____
CD	$ _____	$ _____	$ _____
401K	$ _____	$ _____	$ _____
Other Assets/HSA/FSA	$ _____	$ _____	$ _____

Property

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

_____

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 Program 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: _____