ORTHOPAEDIC HOSPITAL OF WISCONSIN
FINANCIAL ASSISTANCE APPLICATION

Thank you for choosing the Orthopaedic Hospital of Wisconsin for your medical needs. You have expressed an interest in applying for Orthopaedic Hospital of Wisconsin's financial assistance program.

<u>In order to be considered the following documents must be received in our office:</u>

- **Completed application including signature and date**
- **Proof of current monthly income for patient/guarantor and spouse, including: current employment, child-support, alimony, unemployment compensation, worker's compensation, social security, pension, retirement income, other interest or dividends**
- **Rental property income**
- **Proof of government assistance, including food stamps, subsidized housing, or WIC**
- **Complete copy of most recently filed Federal and State income tax returns including all attachments**
- **Current copy of checking and savings account statements showing current balance**
- **Proof of current assets, including: CD's, securities, life insurance, other real estate equity**
- **Completed Attestation letter if being assisted with day to day living expenses**

Do NOT send original supporting documents.

Failure to provide complete application and requested supporting documentation by date identified will result in immediate denial.

<u>Financial assistance is not an insurance plan.</u> Financial assistance may assist with Orthopaedic Hospital of Wisconsin bills for uninsured patients. Refusal to apply for government programs for which you qualify will result in immediate denial for financial assistance. You will receive your determination within 10 days of receipt of the complete financial assistance application and supporting documentation.

<u>Financial assistance does not cover the following services:</u>

- Insurance deductibles or copayments
- Charges in litigation (legal proceedings such as workers compensation, motor vehicle accidents, etc.)
- Outside billing groups, including other hospitals, clinics, labs, physician services, and ambulance transportation.

<u>Please call 414-961-6803 if you have any questions.</u>

Orthopaedic Hospital of Wisconsin Financial Assistance Application

To provide additional family member or family employment information use back of application

MR Number & Account Number to be completed by hospital personnel	*MR number:*	*Account Number(s):*

Please provide the following information completely and accurately. Information is subject to verification.
All fields must be filled out, if it does not apply, please indicate N/A

Applicant Name (First, MI, Last):	Social Security Number:	Date of birth:

Address:	Telephone Numbers: Cell: ( ) Home: ( ) Work: ( )
City/State/Zip Code:	Are you covered under a Health Insurance Plan? □ yes □ no
	Name of Insurance

If married list spouse information and any minor children	Date of Birth for each:	Soc. Sec. Number.:	Relationship to Patient:
1.			
2.			
3.			

Income: Monthly (patient and spouse if married) Or Parents if applicant is a minor		Additional Employers Write on Back	
Household Income (before taxes) (W2 or 1099) Includes Unemployment Income	$	Employer (applicant) or Parent (if a minor)	Phone Number
Pension/Social Security/Disability Income	$	Hire Date	Termination Date
Child Support/Alimony Received **Attach proof of monthly support**	$	Additional Employers in calendar year	Phone Number
Rental Property Income	$	Hire Date	Termination Date
Assets: Checking / Saving Account Balance Don't include balances for retirement accounts	$		
Spouses Employment Information	Phone Number	Spouses additional employment information for calendar year:	Phone Number
Hire Date	Termination Date	Hire Date	Termination Date

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at the time of registration. I understand that providing false information will result in denial of application for any type of financial assistance through Orthopaedic Hospital of Wisconsin. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Orthopaedic Hospital of Wisconsin to obtain such reimbursementt and will assign to Orthopaedic Hospital of Wisconsin, and upon receipt will pay to Orthopaedic Hospital of Wisconsin all the amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such reimbursement or to follow through with the application process or take those actions reasonably necessary or requested by Orthopaedic Hospital of Wisconsin may result in the denial of this application. I also authorize Orthopaedic Hospital of Wisconsin to Check my credit history through the credit bureau, if necessary.

Completed application must be returned by ______________________ to be considered.

Send to Orthopaedic Hospital of Wisconsin
475 W. River Woods Parkway
Glendale, WI 53212
ATTN: Chief Financial Officer

Incomplete application may be denied and returned for missing information.

______________________________ ______________________
Signature of Patient (Responsible Party) Date

Administrative use only

Approvers Signature ______________________ Date ______________________