WESTERN WISCONSIN HEALTH

Financial Assistance Discount Application
It is the policy of Western Wisconsin Health to provide essential medically necessary services regardless of the patient's ability to pay. WWH offers discounts based on family size and annual income.

Please complete the following information and return to the financial counselor or business office manager to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this facility, except for retail cash-based services or those services or equipment purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 3 months or if your financial situation changes.

Name of Household			**Place of Employment**	
Street	**City**	**State**	**Zip**	**Phone**

Name – Self/Dependents	**Date of Birth**	**Name – Self/Dependents**	**Date of Birth**

Reason for Application: The Financial Assistance Programs are not insurance programs nor are they entitlement programs. They are not meant to replace benefits that are or could be received from other payment sources. Please state your reason for needing assistance with your bill: (or attach separate letter)_____

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Proof of income MUST be attached before an application will be considered "Complete". Please attach copies of tax returns, pay stubs, or other information verifying income so that we can process the application.

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, and other miscellaneous sources				
Total Income				

Print name			
Signature		**Date**	

Office Use Only

Patient Name	
Approved Discount	
Approved by	
Date Approved	

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, or three most recent pay stubs/Bank Statements, or Letter of Attestation from 3rd party.		
Insurance: Insurance Cards		
Proof of application for WI Medicaid (for Community Care – Hospital based services)		