REQUEST FOR FINANCIAL ASSISTANCE (Sliding Fee Scale/Charity Care)

It is the policy of Appleton Area Health, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon the family/household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic and ER, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services.

If you have any questions, please call our Patient Account Representative Jodi at 320-289-8523.

This form must be completed every 6 months or if your financial situation changes.

Name of Head of Household		**Place of Employment**		
Street	**City**	**State**	**Zip**	**Phone**
Health Insurance Plan		**Social Security Number**		

Number of related persons living in your household: ☐

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income (Please include a copy of your most current tax return)

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment and dependents				
Rent, interest, dividend, and other income				
Total Income				

Expenses

Description	Weekly Amount	Monthly Amount	Annual Amount
House: Own Rent (Circle One)	$	$	$
Heat/Gas	$	$	$
Food	$	$	$
Insurance Premiums	$	$	$
Electric	$	$	$
Phone	$	$	$
Car Loan	$	$	$
Charge Account Balance	$	$	$
Child Care: Alimony Payments Day Care (Circle One)	$	$	$
Other Medical Expenses	$	$	$
Other Financial Obligations	$	$	$

If there are Other Medical Expenses and Other Financial Obligations, please provide a brief explanation below.

Net Income

Total Annual Household Income	$
Less: Annual Expenses	$
Net Income	$

In order to qualify for the Charity Care program, you must apply for Medical Assistance in your county first.

Have you applied for Medical Assistance with your county? Yes___ No___(please check one)

If No, you must do so.

If Yes, what was the outcome? (If denied, attach copy of denial)____

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Verification Checklist (attach copies)	YES	NO
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other	☐	☐
Income: Prior year tax return, three most recent pay stubs, or other	☐	☐
Insurance: Insurance card(s)	☐	☐
Medicaid: Application made or evidence of rejection	☐	☐

APPLICANT'S COMMENTS: Please tell why you need to file this form, or other information that will help us make a determination on this account

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print):	Date:
Signature:	

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Adjustment % Approved ________________________ Adjustment Amt. Approved ____________________

DOS Covered ___________ to __________________ Applicants Share still owing $ _________________

Applicant to pay $ ________________ Month $ __________________ Lump Sum $________________

Comments:

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Circle One: Approved / Denied

Business Office Manager ____ **Date** _______________

CFO ____ **Date** _______________