UWHealth | UnityPoint Health Meriter

Financial Assistance Application

UW Health
7974 UW Health Ct
Middleton, WI 53562
877-278-6437

Applicant Name *(First, Middle, Last)*	Date	Medical Record # (If Known)

For evaluation for the Financial Assistance Program, please include all the following items, as applicable:

- This Application, signed and dated
- Federal tax returns and supporting schedules (last years)
- Pay stubs (last months)
- Benefit award letters (pension, unemployment, SSI, SSDI)
- 2 Bank statements
- Letter explaining how you are meeting your daily living expenses

From which organizations are you applying for financial assistance? ☐ UW HEALTH - WI & IL Facilities ☐ MERITER

Does the patient currently have insurance coverage? ☐ Yes ☐ No

Coverage: ______________________________

If not, has the patient applied for coverage through the Marketplace (Healthcare.gov)? ☐ Yes ☐ No

Does the patient participate in a Health Sharing Ministry Product? ☐ Yes ☐ No

Does the patient elect to not participate in a government funded insurance program for religious/cultural reasons? ☐ Yes ☐ No

Did the patient/financially responsible party file taxes last year? ☐ Yes ☐ No

If not, why? ______________________________

Patient/Financially Responsible Party

Name *(First, Middle, Last)*	Relationship to Patient	Birth Date *(Month DD, YYYY)*

Address	City	State	ZIP Code

Phone	Household Size (Patient, Spouse and Dependents)	Marital Status

Employment Status	If unemployed, last day/month & year worked
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed	

Employer	Weekly Income	Employment Date *(Month DD, YYYY)*
	Hrs/Week: Pay($)/Hour:	

Spouse/Partner

Name *(First, Middle, Last)*	Birth Date (Month DD, YYYY)	Phone

Address	City	State	ZIP Code

Employment Status	If unemployed, last day/month & year worked
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student ☐ Unemployed	

Employer	Weekly Income	Employment Date *(Month DD, YYYY)*
	Hrs/Week: Pay($)/Hour:	

Dependents

Full Name	**Relationship**	**Birth Date** *(Month DD, YYYY)*
1.		
2.		
3.		
4.		

Monthly Income of Financially Responsible Party and Spouse (if applicable)

Patient/Responsible Party		Spouse	
	Monthly Social Security Income		Monthly Social Security Income
	Date of SSDI Application		Date of SSDI Application
	Pension		Pension
	Unemployment		Unemployment
	Cert of Dep/IRA		Cert of Dep/IRA
	401K Withdrawal		401K Withdrawal
	Rental/Property Income		Rental/Property Income
	Other Income		Other Income

Other Medical Bills Owed (Not at UW Health or Meriter)

Type	List Name/Use for Loans/Credit Cards	Unpaid Balance	Monthly Payment

Assets >$10,000

List any liquid assets you have with a value over $10,000. Do not include your primary home, primary vehicle, or retirement/college savings accounts.

Other Comments

Optional Additional Info (Choosing to answer these questions will not impact your application)

Race: ☐ America Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer

Sex: ☐ Male ☐ Female ☐ Nonbinary ☐ Decline to Answer

Preferred Language: ______________________

Certification

I understand this information will be used only for determination of financial responsibility for my charges at UW Health and will be kept confidential. As part of the Financial Assistance program requirements, I am required to be screened for Medicaid or other public assistance programs, including but not limited to the following: BadgerCare – WI Medicaid; Elderly, Blind, Disabled (EBD); Alien Emergency Medical Assistance (AEMA); Victim of Violent Crime Compensation Fund (VOVC); Presumptive Disability/Medicaid; Social Security Disability/Income (SSD/SSI); Marketplace Health Insurance. My signature authorizes the UW Health to verify any and all information furnished on this form.

If you have questions or concerns, please contact UW Health Customer Service (877-278-6437)

To sign document electronically: Go to "Tools" --> "Fill & Sign"

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*
Name of person completing form if different from patient	Date *(Month DD, YYYY)*

Complaints or concerns with the uninsured patient discount application or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at: 1-877-305-5145 or https://illinoisattorneygeneral.gov/consumers/healthcare.html