midwest orthopedic
SPECIALTY HOSPITAL
In Partnership with the Felician Sisters
10101 South 27th Street / Franklin, WI 53132 / tel 817- 414 - 3960

Financial assistance application form

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social security benefits _____
Pension/retirement income _____
Disability income _____
Unemployment compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food stamps _____
Trust fund distribution received _____
Other income _____
Other income _____
Total gross monthly income $ _____

Monthly living expenses

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses $ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Other assets _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant _____

Date _____

Comments _____

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Letter of support

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To Ascension:

This letter is to advise that (patient's name)_____ receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____

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[Date]

Dear Patient/Applicant,

Midwest Orthopedic Specialty Hospital is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for all of your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of the following items as proof of their income before the application can be processed.

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail or hand deliver your completed application to the following address:

Att: Financial Counselor

10101 South 27th Street

Franklin, WI 53132

If you have any questions about this application, please call one of our Patient Representatives at 414-325-6311.

Sincerely,

Patient Financial Services
Midwest Orthopedic Specialty Hospital

Ascension

Please mail application to the Financial Counselor's hospital address **where you received your services:**

Ascension All Saints Hospital Attn: Financial Counselor 3801 Spring Street Racine, WI 53405	Ascension St Francis Hospital Attn: Financial Counselor 3237 S. 16th Street Milwaukee, WI 53215	Ascension Elmbrook Hospital Attn: Financial Counselor 19333 W North Ave Brookfield, WI 53045
Ascension Franklin Hospital Midwest Orthopedic Specialty (MOSH) Attn: Financial Counselor 10101 S 27 Street Franklin, WI 53132	Ascension St. Joseph Hospital Attn: Financial Counselor 5000 W Chambers Street Milwaukee, WI 53210	Ascension Columbia St. Mary's Hospital Patient Accounting / Office Center P.O. Box 503 Milwaukee, WI 53201-9682
Ascension Calumet Hospital Attn: Financial Counselor 500 S Oakwood Rd Oshkosh, WI 54904	Ascension Eagle River Hospital Attn: Financial Counselor 240 Maple St Woodruff, WI 54568	Ascension St. Mary's Ozaukee Hospital Patient Accounting / Office Center P.O. Box 503 Milwaukee, WI 53201-9682
Howard Young Medical Center Attn: Financial Counselor 240 Maple St Woodruff, WI 54568	Ascension NE WI St. Elizabeth Hospital Attn: Financial Counselor 1506 S. Oneida St Appleton, WI 54915	Ascension Good Samaritan Hospital Attn: Financial Counselor 1120 Pine St Stanley, WI 54768
Ascension Our Lady of Victory Hospital Attn: Financial Counselor 1120 Pine St Stanley, WI 54768	Ascension Sacred Heart Hospital Attn: Financial Counselor 2251 N Shore Dr Rhinelander, WI 54501	Ascension NE WI Mercy Hospital Attn: Financial Counselor 500 S Oakwood Rd Oshkosh, WI 54904
Ascension St. Michael's Hospital Attn: Financial Counselor 900 Illinois Ave Stevens Point, WI 54481	Ascension St. Mary's Hospital Attn: Financial Counselor 2251 N Shore Dr Rhinelander, WI 54501	