midwest orthopedic
SPECIALTY HOSPITAL

Corporate Services
801 S. 60th Street, Suite 150
West Allis, WI 53214

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Midwest Orthopedic Specialty Hospital respects each person's dignity with a special concern for those who struggle with barriers to access healthcare services. We have an equal commitment to manage our healthcare resources as a service to the entire community. Therefore, we provide financial assistance for certain individuals who come to us for emergent or other medically necessary care. As part of the Financial Assistance program requirements, you are required to be screened for Medicaid or other public assistance programs, including but not limited to, the follow: 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.

Financial Assistance Program Application Instructions
Submit the following checked ☒ Items:

(Please send copies, originals will not be returned)
All information is needed for both applicant and spouse

- ☐ Applicant's ID
- ☐ Copy of your most recent paycheck stub/voucher.
- ☐ Verification of monthly income from Social Security if you are retired or on disability. (Example: Bank Statement or Award Letter)
- ☐ Verification of unemployment income.
- ☐ Verification of child support and/or alimony.
- ☐ Verification of pension and/or work comp benefits.
- ☐ Verification of food stamps, FIP Assistance, heating and housing assistance.
- ☐ Applicants that receive financial help from a family member or other person for living expenses must include written statement from this person or statement of support with supporting party's ID.
- ☐ Complete copy of your _____ calendar year signed Federal Tax Return including all schedules if you are self-employed and/or have farm or rental real estate income.
- ☐ If you do not have health insurance:
    1. A letter from your employer and/or your spouse's employer, confirming health insurance coverage is not available.
    2. If you declined health insurance offered through your employer and/or your spouse's employer, submit cost of the premiums.
- ☐ If you do have health insurance:
    1. Proof of premiums you are paying for health insurance coverage.
- ☐ Letter of decision regarding public funded health insurance coverage is required. Please call your local Department of Human Services office to apply for Medicaid/Title 19 and/or medically needy spend down program.

Midwest Orthopedic Specialty Hospital will submit a written response to the applicant upon receipt of a completed application and supporting information. This written response will apply to visits with the first statement date going back one year and forward one year from date of approval, so your prompt attention to complete and return this application is important.

If your application is denied for any reason, submit your appeal within fourteen (14) calendar days of the date of the denial letter to the Office of the Vice President of Revenue Cycle, Attn: 100% Charity Care and Financial Assistance Appeals Committee, Wheaton Franciscan Healthcare Corporate Services Office, 801 S. 60th Street, Suite 150, West Allis, WI 53214, outlining why the application should be reconsidered and providing any additional supporting information.

Date: _____ Account Number(s): _____

Applicant's Name: _____ Patient's Name: _____

Applicant's Address: _____ City: _____ St: _____ Zip: _____

Applicant's Phone No: _____ SSN: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name: _____ SSN: _____ Date of Birth: _____

Dependent's Name	Date of Birth	Dependent's Name	Date of Birth
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED):

APPLICANT

Are you presently employed? ☐ Yes ☐ No Do you file a federal tax return? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No Do you have health insurance? ☐ Yes ☐ No

Hire Date: _____ Monthly amount paid for health insurance: $ _____

How often are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly Hourly Wage: $ _____

How many hours are you scheduled each pay period? ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 120 ☐ Other _____

Present or Last Employer: _____ City: _____ State: _____

Monthly Gross Income: _____ Telephone Number: _____

SPOUSE OF APPLICANT

Are you presently employed? ☐ Yes ☐ No Do you file a federal tax return? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No Do you have health insurance? ☐ Yes ☐ No

Hire Date: _____ Monthly amount paid for health insurance: $ _____

How often are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly Hourly Wage: $ _____

How many hours are you scheduled each pay period? ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 120 ☐ Other _____

Present or Last Employer: _____ City: _____ State: _____

Monthly Gross Income: _____ Telephone Number: _____

OTHER SOURCES OF INCOME (check type and list amount):

☐ Alimony/Child Support _____ ☐ Pension Annuity _____

☐ Social Security _____ ☐ Workman's Compensation _____

☐ Veteran's Pension _____ ☐ Rental Income _____

☐ Unemployment Compensation _____ ☐ Other (Specify) _____

☐ School Grants _____

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to Wheaton Franciscan Healthcare for verification of this financial statement.

_____ _____

Signature of Patient/Applicant Date

_____ _____

Spouse Date