ProHealth Care

Appendix C

Financial Assistance Application
ProHealth Care

_____

I hereby request that ProHealth Care make a written determination of my eligibility for financial assistance. I understand that the information which I submit concerning my annual income, assets and family size is subject to verification by ProHealth Care. I also understand that if the information which I submit is determined to be false, such determination will result in a denial for financial assistance and that I will be liable for charges for the services provided.

Patient Name:_____
Last First Middle Initial

Current Address:_____
Street (No. P.O. Box) City State Zip Code

How Long at Above Address:_____ **Telephone**:_____ **Waukesha County Resident**: **Yes:** ☐ **No:** ☐

If at Above Address Less Than Six Months, Indicate Previous Address Below and Length at that Address:

_____
Street City State Zip Code Length at Address

HOUSEHOLD MEMBERS (INCLUDING PATIENT):

Name	Relationship	Date of Birth	Social Security Number (Mandatory)

EMPLOYMENT, INCOME AND ASSET INFORMATION (ALL AREAS MUST BE COMPLETED):

Are you presently employed? ☐ Yes ☐ No Are you self-employed? ☐ Yes ☐ No

Please list Gross Monthly Income for all household members. Return the following items for verification of income: Tax Return and W-2 for the previous year, copies of check stubs for the last 90 days and, if Home Owner, Property Tax Bill and Mortgage Statement. A determination cannot be made unless this is provided.

Patient or Parent Name:	**Spouse, Parent or Other Name:**
Present or Last Employer:	**Present or Last Employer:**
Employment Dates **From:** **To:**	**Employment Dates** **From:** **To:**
Gross Monthly Wages:	**Gross Monthly Wages:**

ProHealth Care

OTHER SOURCES OF INCOME (check type and list amount for yourself or other household members):

☐	**Alimony/Child Support** _____	☐	**Interest Income** _____
☐	**Social Security** _____	☐	**Worker's Compensation** _____
☐	**Pension Annuity** _____	☐	**Unemployment Compensation** _____
☐	**School Grants** _____	☐	**Auto Liability Income** _____
☐	**Public Assistance** _____	☐	**Rental Income (Net Profits)** _____
☐	**Other (Specify)** _____	☐	**Net Profits from Business** _____

HOME OWNER: **OTHER PROPERTY:**

Home Owner Location:	**Location:**
Assessed Taxable Value:	**Assessed Taxable Value:**
Mortgage Balance Due:	**Mortgage Balance Due:**

RENTER:

Location:	
Monthly Rent Paid:	

AUTOMOBILE(S):

Make/Year/Model	Lien Holder (if other than applicant)	Balance Owed	Monthly Payment

ASSET DETAILS (check type and list amount for yourself or other household members):

PLEASE PROVIDE ASSET INFORMATION FOR HOUSEHOLD MEMBERS. A DETERMINATION CANNOT BE MADE UNLESS THIS INFORMATION IS PROVIDED. ALL INFORMATION IS SUBJECT TO VERIFICATION.

☐	**Checking Account** _____	☐	**Savings Accounts** _____
☐	**CD (s)** _____	☐	**Income Property** _____
☐	**IRA (s)** _____	☐	**Other Real Estate** _____
☐	**TSA (s)** _____	☐	**Stocks/Bonds/Annuities**
☐	**401 (k)s** _____	☐	**Recreation Vehicles (Boat, RV, etc.)**_____

☐ **LIFE INSURANCE** **Policy Type:** ☐**Term** ☐**Whole** **Today's Cash Value $**_____

IF YOU ARE SEEKING AN ELIGIBILITY DETERMINATION FOR SERVICES ALREADY RENDERED BY PROHEALTH CARE, PLEASE LIST DATES OF SERVICES AND PATIENT NAME.

Name: _____ Service Date: _____

_____ _____

I affirm that the information given in this document is true and correct to the best of my knowledge. I authorize the release of information to ProHealth Care for verification of this financial statement. ProHealth Care reserves the right to reverse a determination if it is found that accurate and complete information was not provided during the application process.

Date: _____ Signature: _____
(Signature of Patient/Guarantor/Spouse)

ProHealth Care Personnel Only

Date Received: _____