



Dear Patient or Responsible Party:

Southwest Health Center, Inc. treats all patients regardless of payment source. Part of our job is to help uninsured and under-insured patients find other financial resources.

Financial Assistance is a Southwest Health Center, Inc. program that assists uninsured or under-insured patients with their hospital bills. The first requirement is to apply for state medical assistance. To apply for Medicaid coverage online please go to this website, www.access.wisconsin.gov or call 1-888-794-5780.

Once you receive your Medicaid approval/denial letter please attach a copy of the letter with this application and all other required documents. At the end of the application is a list of information that should be returned with the application.

Southwest Health Center, Inc. cannot consider your application until the following steps are completed.

- Step 1: Obtain Medicaid approval/denial letter and include with this application
 - Step 2: Fully complete, sign and date this application
 - Step 3: Include the following required documents:
 - Two months of prior paystubs for each employed adult.
 - Most recent two months of bank statements, savings and checking.
 - Most recent filed State and Federal Income Tax Returns. Including all schedules filed.
- If applicable to the applicant:
- Student Aid report for current school year if attending schooling past high school.
 - Social Security Income annual report
 - Pension annual report
- Step 4: Submit by mail or in person this application along with all required documentation to Patient Financial Services at Southwest Health Center at 1400 Eastside Rd. Platteville, WI 53818

If you have any questions, please do not hesitate to contact us at (608)342-4717. We would be more than happy to assist you with any questions or concerns.

Sincerely,

Patient Financial Services

Financial Assistance Application

NAME _____ SOC SEC# _____ BIRTHDAY _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER (NAME & ADDRESS) _____

SPOUSE _____ SOC SEC# _____ BIRTHDAY _____

EMPLOYER (NAME & ADDRESS) _____

DEPENDENTS Name/Age _____ Name/Age _____

 Name/Age _____ Name/Age _____

 Name/Age _____ Name/Age _____

PLEASE PROVIDE INFORMATION ON SOURCES OF INCOME FOR YOUR HOUSEHOLD BELOW:

Source of Income*	Monthly Amount	Name of Individual Receiving Income

*INCOME: Represents total cash receipts for all sources before taxes included, but not limited to, wages, public assistance, social security, unemployment or workers' compensation benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust incomes, tax refunds, and compensation for injury claims.

* NOTE BELOW ANY FINANCIAL CHANGES, SUCH AS JOB LOSS, DIVORCE, DEATH, OR ANY OTHER HARDSHIPS:

Please fill in the boxes below to provide us with more information on your financial responsibilities:

Property/Homestead		
Location:	Assessed Tax Value:	Mortgage Balance:
Location:	Assessed Tax Value:	Mortgage Balance:
Location:	Assessed Tax Value:	Mortgage Balance:

Bank Account Balances (Patient and Spouse)					
Type	Location	Amount	Type	Location	Amount
Checking			Credit Union		
Checking			CD's		
Savings			IRA's		
Savings			Other		

Auto/Vehicle		
Make & Year:	Estimate Value:	Loan Balance:
Make & Year:	Estimate Value:	Loan Balance:
Make & Year:	Estimate Value:	Loan Balance:

Other Assets-Recreational Vehicles		
Type (Boat/Motorcycle/Snowmobile/RV/etc)	Estimated Value	Loan Balance

Monthly Expenses (Please feel free to use the back of this page for additional space if needed)			
Rent		Alimony/Child Support	
Mortgage		Medications	
2 nd Mortgage		Insurance Premiums	
Utilities		Transportation	
Cable/Satellite		Medical Bills (Specify)	
Phone (Including Cell)		Credit Card (Specify)	
Food		Other (Specify)	

PLEASE SEE BACK PAGE →

Please read and sign below:

I attest that the information on this application is accurate to the best of my knowledge and truly represents my current financial situation; and I authorize Southwest Health Center, Inc. to verify any information given on this application in the determination of my eligibility for Financial Assistance.

Patient/Responsible Party Signature

Date

Important Note Reminder: To process your application, the following information is necessary:

- Medicaid approval/denial letter
- Financial Assistance application, filled out, signed and dated
- Two months of prior paystubs for each employed adult.
- Most recent two months of bank statements, savings and checking.
- Most recent filed State and Federal Income Tax Returns. Including all schedules filed.

- If applicable to the applicant:
 - Student Aid report for current school year if attending schooling past high school.
 - Social Security Income annual report
 - Pension annual report

Please submit by mail or in person this application, along with all required documentation to:

Southwest Health Center

Attn:

Patient Financial Services

1400 Eastside Rd. Platteville, WI 53818