Marshfield Clinic
Health System

Financial Assistance Application Checklist

Completing this application will assist Marshfield Clinic Health Systems, Inc. determine if you are eligible to receive free or discounted care or qualify for other public programs that can help pay for your health care.

Complete, sign, date and return application.

- This includes completing the authorization box in the upper right corner of the form for Marshfield Clinic Health Systems, Inc. and their affiliated entities to share your information.
- Provide copies of required supporting documentation.

If you have questions or need help completing the application, contact us at 1-715-389-4475 or 1-800-782-8581, ext. 9-4475.

Mail completed financial assistance application and copies of required documentation to:

Marshfield Clinic Health System
Patient Financial Assistance Center
1000 North Oak Avenue
Marshfield, WI 54449

Or scan and email to: PACCounselorShared@marshfieldclinic.org

Taxes *(for all adult household members)*

- Most recent Federal tax return and/or the most recent Federal tax return on which the applicant was claimed as a dependent, if applicable, including:
  - All W-2 and 1099 forms (including the W-2 associated with the tax return)
  - All schedules
  - All additional attachments

  If you do not have a copy of your most recent tax return, you can request a transcript by calling **1-800-908-9946** or go online to http://www.irs.gov/Individuals/Get-Transcript.

  If you are not required to file a tax return, complete a 4506T form. You can get this form online at https://www.irs.gov/pub/irs-pdf/f4506t.pdf.
- Your most current W-2 and 1099 forms

Wages *(for all adult household members)*

- Most recent payroll stub for each employer you worked for in the current year and final payroll stub from all previous employers in current year:
  - Must show year-to-date earnings
  - Required for each adult working member in the household (including married couples even if living apart, significant others living in the household with a child in common, or adults living in the household if claimed as a dependent)
- For cash – complete an Employer Wage Verification form

Unearned income *(for all adult household members)*

- Statements for retirement funds, pensions, 401K, annuities
  – Only applicable if monthly/quarterly income is received
- Award letters for Social Security, Workers' Compensation, and disability
- Divorce decree for verification of maintenance (alimony)
- Child support verification and foster care income
- Tribal income, rental income, interest income, dividends, and/or royalties
- Unemployment – for a year-to-date print out, go to http://dwd.wisconsin.gov/uiben/online
- Veteran's benefits
- Estate or trust

Other programs *(not required)*

- Approval or denial letter from Medical Assistance, Public Assistance, Supplemental Security Income, and Social Security Disability
- Approval or denial letter from Tribal Benefits
- Copies of legal and immigration documents may be requested to determine sponsorship and financial responsibility; for example: current or expired Visa; permanent resident card

Marshfield Clinic Health System

Financial Assistance Application

Fill in all blanks on application to ensure timely processing. Enter "n/a" or draw a line through a section if it is not applicable to you.

I authorize Marshfield Clinic Health System, Inc. and their affiliated entities to share my financial information in this application for the purpose of applying for assistance for my health care costs:

☐ Yes, share
☐ Do not share, I want to apply separately

Patient signature _____

Demographic Information

Applicant's name	Phone	Date of birth	Applicant's medical history number

Are you claimed as a dependant: ☐ Yes ☐ No

If yes, is your primary residence the same at the tax filer: ☐ Yes ☐ No

Address

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

City	County	State	ZIP

Is applicant applying for assistance: ☐ Yes ☐ No Type of assistance: ☐ Existing balance only ☐ Existing balance and future charges

List the names and provide information for all others residing in your home. Check (✓) "yes" for each individual who is applying for assistance and "no" for each individual who is not applying for assistance:

Name	Date of birth	Relationship	Claimed as dependent	Income if 18 years or older	Applying for assistance
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Is Marshfield Clinic Health System your primary care facility: ☐ Yes ☐ No If no, list name/location _____

Income Sources – Monthly Gross (Before Taxes)

	Applicant		Spouse/Co-applicant	
List all employers for current year				
Start and end dates of employment *(mm/dd/yyyy)*				
Wages	Hourly wage $	Hours worked/week	Hourly wage $	Hours worked/week
Social Security	$		$	
Retirement/Pension	$		$	
Veterans benefits	$		$	
Disability	$		$	
Unemployment	$		$	
Workers Compensation	$		$	
Child support	$		$	
Foster care	$		$	
Rental income	$		$	
Interest and dividend income	$		$	
Alimony (maintenance)	$		$	
Estate or trust	$		$	
Royalties	$		$	
Other income (specify)	$		$	

Health Insurance Benefits	Applicant	Spouse/Co-applicant
Insurance	Effective date	Effective date
Do you have Medicare	☐ Yes ☐ No ☐ SeniorCare ☐ Part A ☐ Part B ☐ Part C ☐ Part D	☐ Yes ☐ No ☐ SeniorCare ☐ Part A ☐ Part B ☐ Part C ☐ Part D
Do you have BadgerCare/ Medical Assistance	☐ Yes ☐ No ☐ Denied If yes, state _____	☐ Yes ☐ No ☐ Denied If yes, state _____
Does your employer provide you with a payment to cover your medical/health expenses	☐ Yes ☐ No	☐ Yes ☐ No
Do you receive food share, energy assistance or income-based housing	☐ Yes ☐ No	☐ Yes ☐ No
Are you pregnant	☐ Yes ☐ No	☐ Yes ☐ No
Are you deemed disabled through the Social Security Administration	☐ Yes ☐ No	☐ Yes ☐ No

This information is confidential and is for review of your immediate situation.

I understand that I am responsible to report any changes to my application information (ex: marriage, divorce, address, income, or employment) within 30 days. I/We certify the above information is correct and voluntarily authorize you to obtain information relative to my decision. I/We understand that failure to comply with the application requirements of the financial assistance policy may result in denial of my application or the termination of an existing approval.

_____ _____ _____ /_____ /_____
Signature | Social Security number | Signature date (month/day/year)

_____ _____ _____ /_____ /_____
Spouse/Co-applicant signature | Social Security number | Signature date (month/day/year)

(A second signature is required for married couples even if living apart, domestic partnerships or unmarried couples living together with a child in common.)

