Marshfield Clinic
Health System

Financial Assistance Application

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.

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.

What to Expect After You Apply

- Allow 30 days for your application to be processed.
- If your application is incomplete, you will receive a letter explaining the information needed to process your application.
- If your application is approved you will receive a letter notifying you of your financial award.
- If your application is denied, you will receive a letter notifying you, in which you can appeal our decision within 90 days of the denial.

Documentation Required

***Federal Income Tax Return for the most recent tax year.**

- If claimed as a dependent, also include that tax filers Federal Income Tax Return for the most recent tax year.
- Include all W2's, 1099's, schedules, and attachments for all tax returns provided.

How to obtain a copy of your Federal Income Tax Return – call 1-800-908-9946 or go online to http://www.irs.gov/individuals/get-transcript.

***Income Verification – See Documentation Required under income.**

- If claimed as a dependent, also include that tax filers income information.
- Include income for all dependents over 18 years old or older.

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

Failure to comply with the requirements of the financial assistance policy may result in denial or the termination of an existing approval.

For referral purposes only to screen for additional assistance programs.

☐ Are you pregnant ☐ Are services related to an accident Date of accident _____

☐ Are you a US Citizen ☐ Are services Workers Comp. related Date of injury _____

Insurance Coverage

Insurance Company name _____ Policy holder _____

Effective date _____ Policy number _____ Group number _____

Who is covered under this insurance plan _____

Guarantor name	Phone	DOB	Guarantor MHN
Address (city, state and ZIP)		☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	

Tax Return – Have you filed a Federal Income Tax return for the most recent tax year: ☐ Yes ☐ No
Are you claimed as a dependent on another person's tax return: ☐ Yes ☐ No
If yes, provide a complete copy of your Federal Tax return including W2's and/or 1099's including all schedules and attachments.

Household – List the names and provide information for spouse, co-applicant and all dependents. If additional information, attach a 2nd page.

Name	Date of Birth	Relationship	Claimed as Dependent	Medical History Number	Applying for Assistance
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

INCOME	Guarantor – Monthly Income	Spouse/Co-Applicant – Monthly Income	Documentation Required
List all employers for the current year. If additional information, attach a 2nd page. **(Guarantor)** Employer _____ Start date _____ End date _____ Hourly wages $ _____ Hours worked per week _____ **(Spouse/Co-Applicant)** Employer _____ Start date _____ End date _____ Hourly wages $ _____ Hours worked per week _____	$ ☐ N/A	☐ N/A $	Most recent paystub for all employers worked during the current year showing YTD income
Self-Employment	$	$	Complete Federal Income tax return – including all W2's,1099's, schedules and attachements.
Social Security/Supplemental Security income	$	$	Current year social security benefit letter
Retirement/Pension	$	$	Pension/Retirement disbursement letter or 1099
Veteran benefits income	$	$	VA benefit verification letter
Rental income received monthly	$	$	Lease agreement, tax return, or 1099
Unemployment benefits Start date _____ End date _____	$	$	Unemployment verification letter or print out from Wi. Dept. of Unemployment showing YTD payments received
Workers compensation Start date _____ End date _____	$	$	Workers compensation letter or print out of payments from Workers Compensation Co.
Disability Income (short or long-term) Start date _____ End date _____	$	$	Disability verification letter or print out from the disability Ins. Co. showing YTD payments received.
Child/Spousal support/alimony/maintenance	$	$	Court order showing awarded monthly payment or a print out showing YTD payments received.
Other Income (specify)	$	$	Documentation showing YTD income and documentation of frequency received

I/We certify the above information is correct and voluntarily authorize you to obtain information relative to my decision.

_____ _____ _____/_____/_____
Signature Social Security Signature date (m/d/y)

_____ _____ _____/_____/_____
Spouse/Co-applicant signature Social Security Signature date (m/d/y)

