Today's Date (MM/DD/YYYY): {To be returned within 30 days}
Medical Record#:
Guarantor #:
Referred By:
Applicants Name *(First, Middle, Last):*

GUNDERSEN HEALTH SYSTEM®

FINANCIAL ASSISTANCE APPLICATION

Send to: Gundersen Health System, Attn: CFS/NCA3-01
1900 South Ave., La Crosse WI 54601

HEALTH INSURANCE If yes, please provide information and copy of insurance card	
Insurance Co Name and Address:	Policy Number:

SERVICE LOCATION	
☐ Gundersen Lutheran Medical Center/Clinics	☐ Gundersen St. Joseph's Hospital and Clinics
☐ Gundersen Boscobel Area Hospital and Clinics	☐ Gundersen Tri-County Hospital and Clinics
☐ Gundersen Palmer Lutheran Hospital and Clinics	☐ Gundersen Moundview Hospital and Clinics
☐ Gundersen St. Elizabeth's Hospital and Clinics	

PLEASE CHECK ALL BOXES BELOW THAT APPLY AND PROVIDE SUPPORTING DOCUMENTATION	
☐ Medicaid Eligible, but not for date of service or for non-covered service	☐ Deceased with no estate
☐ Homeless - Explain:	☐ Incarceration in penal institution

PLEASE ATTACH COPIES OFTHE FOLLOWING. (Not applicable to families with annual income at or below 200% of the current FPG).	
☐ Copies of 401K/Retirement/CD/etc. Statements	☐ Submit a letter describing your financial situation
☐ Copies of pay stubs for 60 Days for all income reported	☐ Copies of Social Security Benefits (if applicable)
☐ Copies of unemployment statements for 60 days	☐ Copies of checking and savings bank statement(s)
☐ Copies of property tax statement	☐ Copies of mortgage balance statement

Filed Federal income taxes? To request a copy of your taxes, please call 1-800-829-1040
☐ Yes - Please send the most recent Federal income tax returns and supporting schedules.
☐ No - Please explain why:

I have applied for or will apply for federal or state medical assistance
☐ Yes ☐ No - Not a citizen ☐ No - Over income ☐ No - Other reason, why?

Email Preference:	
I understand that unencrypted email is not a secure form of communication and that there is some risk that the information contained in emails may be misdirected, accessed, or intercepted by unauthorized third parties. I request that Gundersen Health System communicate information related to this Financial Assistance Application with me via email. I understand that I can revoke this request at any time.	☐ Yes ☐ No
Email Address:	

PATIENT/RESPONSIBLE PARTY

Please check one: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/DD/YYYY)*	
Street Address	City	State	Zip Code
Phone Number:	Household Size *(Patient, Spouse & Dependents)*		
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name and Address		
Hire Date: *(MM/DD/YYYY)*	Position:	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐Yes ☐No If yes, provide tax return of those claiming you.

Unemployed: *(MM/0D/YYYY)*	Average Gross Monthly Income:	Monthly SSI/SSDI:

SPOUSE (If applicable)

Name *(First, Middle, Last)*	Social Security Number	Birth Date *(MM/OO/YYYY)*	Phone Number:

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name, Address, and Phone Number:

Hire Date: *(MM/DD/YYYY)*	Position:	How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Bi-Monthly	Are you claimed on another tax return? ☐ Yes ☐ No If yes, provide tax return of those claiming you.

Unemployed: *(MM/DD/YYYY)* From: To:	Average Gross Monthly Income: $	Monthly SSI/SSDI: $

DEPENDENTS **(If more than 4 dependents use a separate page}**

Full Name	Relationship	Birth Date *(MM/DD/YYYY}*	Claimed as a Dependent on Taxes	
1.			☐ Yes	☐ No
2.			☐ Yes	☐ No
3.			☐ Yes	☐ No
4.			☐ Yes	☐ No

OTHER MONTHLY INCOME (Please attach copies of your documents to support this income)

Other Wages	$	Rental Income	$	Alimony/Child Support	
Pension	$	Disability Income	$	Unemployment	$
Misc. Income	$	Veterans Benefits	$	Interest/Dividends	$

PRIMARY EXPENSES: (Not applicable to families with annual Income ator below 201% of the current FPG}

TYPE	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
Rental Payment	$	$	$
Primary Home	$	$	$
2nd Mortgage	$	$	$
Secondary/Vacation Home/Land	$	$	$

☐ None - Please explain why you have no rent or mortgage:

AUTO/MOTORCYCLE/RECREATION VEHICLES (Not applicable to families with annual Income at or below 201% of the current FPG)

TYPE/MAKE/MODEL/YEAR	MONTHLY PAYMENT	ESTIMATED VALUE	UNPAID BALANCE
	$	$	$
	$	$	$
	$	$	$

ASSETS (Not applicable to families with annual income at or below 201% of the current FPG)

Checking Balance	$	Savings Balance	$
Stocks/Bonds	$	CD	$
401K	$	IRA	$
403B	$	Other/HSA/FSA	$

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED

Patient/Responsible Party Signature	Date

Spouse (If applicable) Date

From: To: $ $

CERTIFICATION: I certify the preceding income/expense Information is true and correct. Please be aware we may review the information you provided In conjunction with your credit report. I understand if I knowingly provide untrue information in the application, I will be ineligible for financial assistance and the financial assistance granted to me may be reversed and I will be responsible for the medical bills.