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| **Your application will be Denied and returned as incomplete if the following items are not included with the application.** |
| **Income Verification:** Prior year Federal tax return or Social Security Statement  |
| **Proof of application for WI Medicaid** (for Community Care – Hospital based services) Apply at this Web Site: https://access.wisconsin.gov/ or call 1-888-283-0012. Must apply to be considered for discount on hospital services. *Not applicable if applying for assistance for Rural Health Clinic services only.*  |

**Financial Assistance Discount Application**

It is the policy of Western Wisconsin Health to provide essential medically necessary services regardless of the patient’s ability to pay. WWH offers discounts based on family size and annual income.

Please complete the following information and return to the financial counselor or business office. You must provide proof of income for your application to be processed, please see above. We will process your application based on your Family size and your AGI (adjusted gross income) from your taxes. Without taxes your application will be denied as incomplete. Pay stubs are not adequate documentation. If you have not filed your tax return yet, we will need all W-2’s.

The discount will apply to all services received at this facility, except for retail cash-based services or those services or equipment purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 3 months or if your financial situation changes.

|  |  |
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| **Name of Household** | **Place of Employment (self and spouse)** |
| **Patient Street address** | **City** | **State** | **Zip** | **Phone** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name – Self/Dependents** | **Date of Birth** | **Name – Self/Dependents** | **Date of Birth** |
| 1. |  | 6. |  |
| 2. |  | 7. |  |
| 3. |  | 8. |  |
| 4. |  | 9. |  |
| 5. |  | 10. |  |

Reason for Application: The Financial Assistance Programs are not insurance programs nor are they entitlement programs. They are not meant to replace benefits that are or could be received from other payment sources. Please state your reason for needing assistance with your bill: (or attach separate letter.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Source** | **Self** | **Spouse/other** | **Total** | **Proof Attached?** |
| Gross wages, salaries, tips, etc. (from taxes, W-2) |  |  |  |  |
| Unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension or retirement |  |  |  |  |
| Other reportable income  |  |  |  |  |
|  |  |  |  |  |
| **Print name** |  |
| **Signature** |  | **Date** |  |

