Application for Financial Assistance

Patient Information

Name_____

Date of Birth_____

Address_____

_____

Social Security #_____
(Not required if you are uninsured)

Phone Number_____

Guarantor Information

In cases in which a spouse or partner is guarantor for the patient, or in which a parent or guardian is guarantor for a minor, the following must be completed.

Guarantor Name_____

Guarantor Address_____

_____

Guarantor phone number_____

Family/Household Information

Spouse or Partner's Name_____

Spouse or Partner's Date of Birth_____

Dependent's Names:

Name_____Birthdate_____

Name_____Birthdate_____

Name_____Birthdate_____

Name_____Birthdate_____

Name_____Birthdate_____

Name_____Birthdate_____

Patient's Family Income and Employment Information

Patient's Employer Name_____

Patient's Employer Address_____

_____

Patient's Employer Phone_____

Guarantor/Spouse/Partner Employer Name

_____

Guarantor/Spouse/Partner Employer Address

_____

_____

Guarantor/Spouse/Partner Employer Phone

_____

Insurance Information

☐ Patient ☐ Guarantor

☐ Spouse ☐ Partner

Health Insurance Name_____

☐ Medicare

☐ Medicare Supplement Name

_____

☐ Medicaid

Please complete this form and submit it along with the required information listed on the website. For fastest processing, please email your submission to cs-pfs@rogershospital.org.

Submissions may also be mailed to:
Rogers Behavioral Health System
Patient Financial Services Department
34700 Valley Road
Oconomowoc, WI 53066

Annual Income

Patient wages	$
Guarantor/Spouse/ Partner's Wages	$
Farm or Self-employment Income	$
Temporary Assistance for Needy Families	$
Social Security/Disability	$
Unemployment/Worker's Compensation Benefits	$
Alimony/Child Support/ Other Spousal Support	$
Pension/Annuities	$
Veteran's Pension	$
Veteran's Disability	$
Other Income	$
Total gross income from all sources for the past 12 months	$

Certification

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

_____
Applicant Signature

_____
Signature Date