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

GUNDERSEN HEALTH SYSTEM

NHSC Financial Assistance Application

Send to: Gundersen Health System, ATTN: CFS/NCA3-01
1900 South Ave., La Crosse, WI 54601
financialassistance@gundersenhealth.org

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

SERVICE LOCATION
☐ Gundersen Boscobel Area Hospital and Clinics
☐ Gundersen St. Joseph's Hospital and Clinics
☐ Gundersen St. Elizabeth's Hospital and Clinics

PLEASE CHECK ALL BOXES BELOW THAT APPLY AND PROVIDE SUPPORTING DOCUMENTATION	
☐Homeless – Explain:	☐ Deceased with no estate
	☐ Incarceration in penal institution

PLEASE ATTACH COPIES OF THE FOLLOWING REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION	
☐ Submit a letter describing your financial situation	☐ Copies of unemployment statements for 30 days
☐ Copies of pay stubs for 30 Days for all income reported	☐ Copies of Social Security Benefits (if applicable)

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 (Not applicable to households with annual income at or below 200% of the current FPG)

☐ Yes ☐ 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)*	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:		
Hire Date: (*MM/DD/YYYY)*	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: $	

SPOUSE (If applicable)

Name *(First, Middle, Last)*	Birth Date *(MM/DD/YYYY)*	Phone Number:
Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Student ☐ Retired	Employer Name:	
Hire Date: (*MM/DD/YYYY)*	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 four 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	$

AUTO/MOTORCYCLE/RECREATIONAL VEHICLES (NOT APPLICABLE TO HOUSEHOLDS WITH ANNUAL INCOME AT OR BELOW 200% OF THE CURRENT FPG)

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

PRIMARY EXPENSES: (NOT APPLICABLE TO HOUSEHOLDS WITH ANNUAL INCOME AT OR BELOW 200% 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:

ASSETS (NOT APPLICABLE TO HOUSEHOLDS WITH ANNUAL INCOME AT OR BELOW 200% OF THE CURRENT FPG)

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

SIGNATURE REQUIRED IN ORDER FOR APPLICATION TO BE PROCESSED

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.

Patient/Responsible Party Signature	**Date:**
Spouse (If applicable)	**Date:**