Dear Patient,

Advanced Spine Center of Wisconsin has a financial assistance program. To determine if you are eligible to receive financial assistance, please complete, sign and return the enclosed application, along with the documents listed to the attention of Kristopher Karns at the following address:

Advanced Spine Center of Wisconsin
1380 Tullar Road
Neenah, WI 54956

All information relating to financial hardship requests will be kept confidential.

To ensure timely processing we request the completed application and related documents be returned to us **promptly, legibly and completely**. *Failure to return the completed documents and supporting materials (paystubs etc) within 30 days from the date of this letter will result in ineligibility.*

Sincerely,

Kristopher Karns
Business Office Manager
Advanced Spine Center of Wisconsin
1380 Tullar Road
Neenah WI 54956
Office: 920-215-3603

Financial Assistance & Hardship Application

Patient Information:

Patient Account #_____ Total Balance Owed: $_____

Patient Name: _____
Date of Birth: _____

Address:
_____

City: _____ State: _____
Zip Code: _____

Home Phone: _____
Cell or Work Phone: _____

Social Security #:_____

List all persons living in the household:

Name:	Age:	Relationship to Patient

Are you currently receiving food stamp assistance? Yes_____ No _____

Income Verification: The following attachments are required to process your application. Advanced Spine Center of Wisconsin staff can assist in copying your paperwork.

Please return and copy all that apply:

- Tax returns from last year
- Bank or Credit Union statements from the previous month
- Past two pay stubs or a letter from the employer(s) for all members of the household receiving income OR proof of unemployment.

- A copy of last check received from any social security, disability social security or supplement social security benefits for you or any members of your household or a letter from Social Security agency indicating the amount awarded.

Monthly Expense Verification Requirements:

- Mortgage/Rent Receipt
- Credit Card Statements
- Car Payment Invoices
- Medical Bill Statements with an amount due greater than $500

Employee Information:

Patient's Current Employer:
_____

Employer's Address:
_____

Job Title:
_____

Gross Monthly Income $_____ Net Monthly Income $_____

Date this employment began:
_____

Deductions taken from paycheck besides taxes:
_____

Name of Spouse's Current Employer:
_____

Employer's Address:
_____

Job Title:
_____

Gross Monthly Income $_____
Net Monthly Income $_____

Date this employment began:

_____

Deductions taken from paycheck besides taxes:

_____

Other Household Monthly Income:

Social Security Income	$
Disability Income	$
Pension	$
Veterans Benefits	$
Child Support or Alimony	$
Welfare	$
Unemployment Benefit Income	$
Workers Compensation	$
Income from Roommate/Rental Property	$
Other Income (explain)	$

Additional Information:
Have you applied for Medicaid benefits? Yes _____ No _____
If yes, Date applied? _____

Have you been denied by Medicaid benefits in the last 12 months? Yes_____
No_____

I have applied for Social Security Income. Yes _____ No _____

Name of Bank: _____
Checking Account Yes _____ No _____
Approximate Balance $_____

Do you own your home? Yes _____ No _____

Type of Vehicle_____ Year_____

Type of Vehicle_____Year_____

Type of Vehicle_____Year_____

Monthly Expenses

Rent/Mortgage Payment	$
Renter's/Mortgage insurance (if not included in payment)	$
Property Taxes (if not included in payment)	$
Utilities: Water/Sewage	$
Gas	$
Electric	$
Telephone (home and cell)	$
Other (explain)	$
Child Care/Tuition	$
Alimony/Child Support (if not deducted from paycheck)	$
Food	$
Medication not reimbursed by insurance	$
Car Payment	$
Car Insurance	$
Gasoline	$
Health Insurance (not deducted from paycheck)	$
Life Insurance (not deducted from paycheck)	$
Other monthly living expenses (explain)	$
	$
Total Monthly Expenses	$

I hereby certify that the answers given are correct and true to the best of my knowledge. I understand that the information which I submit is subject to verification by Advanced Spine Center of Wisconsin for the sole purpose of assessing financial need. I also acknowledge that completion of this form does not guarantee what action may or may not be taken by Advanced Spine Center of Wisconsin.

Sign by Patient:_____ Date: _____

Financial Counselor Comments:

_____
_____
_____
_____
_____
_____
_____

Date reviewed: _____
by: _____

Gross Yearly Income $_____
Members in Household_____

Net Monthly Income $_____
Monthly Expenses $_____

Difference $_____
Recommended Amount of Assistance $_____