

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed. *

SCREENING INFORMATION

Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient's medical care related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation; we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name	Patient last name
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birthdate	Account #
Person Responsible for Paying Bill	Relationship to Patient	Birthdate
Mailing Address _____ _____ _____ City State Zip Code		Social Security # (optional)
Employment status of person responsible for paying bill <input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (_____)		Main contact number(s) () _____ () _____ Email Address: _____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage or adoption who live together.

FAMILY SIZE _____

Attach additional page if needed

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

FINANCIAL ASSISTANCE APPLICATION FORM – CONFIDENTIAL (cont.)

INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*)

Income verification is required to determine financial assistance.

All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a signed written statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation. Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

ADDITIONAL INFORMATION

Financial Assistance does not cover the following: Non-Employed Wellfound Behavioral Health Hospital (WBHH) physician(s) care for you at our hospital, ambulance services, physician fees in lab, imaging or therapy services, retail pharmacy costs, express clinics, services provided with transfers outside of hospital or virtual visits.

PATIENT AGREEMENT

I understand that WBHH may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

Signature of Person Applying

Date

CONTACT INFORMATION

For questions or to submit your application, please email the Financial Assistance Office at wellfoundfinancialassistance@wellfound.org.