

Vernon Health, Inc.  
**FINANCIAL ASSISTANCE APPLICATION**

**PERSONAL INFORMATION**

Today's Date:		Guarantor Number:
<b>HEAD OF HOUSEHOLD PERSONAL INFORMATION:</b>		<b>SPOUSE PERSONAL INFORMATION: (IF APPLICABLE)</b>
First Name:		
Middle Initial:		
Last Name:		
Date of Birth:		
Street Address, City, State ZIP Code:		
Employer Name and Address:		
<input type="checkbox"/> Full-Time		<input type="checkbox"/> Full-Time
<input type="checkbox"/> Part-Time		<input type="checkbox"/> Part-Time
<input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired		<input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired

**DEPENDENTS (IF MORE THAN 6 DEPENDENTS, USE SEPARATE PAGE)**

Full Name:	Relationship:	Birth Date:

**CHECK ALL BOXES BELOW THAT APPLY:** We recommend you apply for Wisconsin Medical Assistance (Medicaid) approval unless you qualify for a religious exemption. This will not result in a denied application.

I have applied for or will apply for federal or state medical assistance?  Yes  No

- Medicaid eligible, but not for date of service or for non-covered services
- I have health insurance, but not for date of service or the service was not covered or applied to deductible
- Deceased with no estate

Religious Exemption (Federal Exemption for the Affordable Care Act)

**PROVIDE ALL SUPPORTING DOCUMENTATION FOR THE ITEMS BELOW:**

Current Federal Tax Return

Letter describing your financial situation

Checking and Savings bank statements  
(include last 3 months)

Pay Stubs (include last 2)

Do you have health insurance? **Y N** If no, we recommend you apply for Wisconsin Medical Assistance (Medicaid) approval unless you qualify for a religious exemption. This will not result in a denied application. Questions can be directed to the contact at the bottom of the application.

**OTHER MONTHLY INCOME/BALANCES (NA for families at or below 200% of the most current FPG)**

Adjusted Gross Income: \$	Rental Income: \$	Short/Long Term Disability: \$	Social Security/SSI: \$
Pension: \$	Workers Comp: \$	Alimony/Child Support: \$	Other: \$
Veterans Benefits: \$	Interest/Dividends \$	Checking Balance: \$	Savings Balance: \$

**CERTIFICATION**

I certify that the information listed in this application is true and correct. Any false information presented on this application may result in a declined financial assistance determination.

**Patient/Responsible Party Signature:**

**Date:**

Applications and supporting documentation can be dropped off at Vernon Health Hospital at the main lobby registration desk, or mailed to:

Vernon Health-Patient Accounts  
507 S. Main Street  
Viroqua, WI 54665

Please call (608) 637-2101 with any questions.