RETURN COMPLETED APPLICATION to Patient Financial Services
Attention Financial Assistance
If you have questions about this application please contact us at 715-268-8000 ext. 0278

Amery Regional Medical Center Financial Assistance Program Application

Name	Home Phone	ARMC Guarantor Number		
Address	City		State	Zip
Date of Birth	Marital Status	Spouse's/Other household adult's name		
Applicant	**Spouse's / Other Household Adults**			
Employer	Employer			
Employment (FT/PT, Salaried/Hourly) # of hrs/wk?	Employment (FT/PT, Salaried/Hourly) # of hrs/wk?			

Total Household Members			
How many claimed on taxes?		Name:	Date of Birth:
# Self / Spouse	# Dependents	Name:	Date of Birth:
		Name:	Date of Birth:
		Name:	Date of Birth:
		Name:	Date of Birth:

Income and Assets

REQUIRED DOCUMENTS That must be RETURNED for APPLICATION to be PROCESSED are	**1. A copy of your most recent income tax return** **2. Copies of your 2 most recent paycheck stubs** **3. Copies of Social Security/Retirement monthly benefits** **4. Copies of Unemployment/Workers Comp monthly benefits**

INCOME - List all household Income	**Monthly Income Self**	**Monthly Income Spouse/Other**	**Assets (what you own)**	
Wages and tips (Gross)	$	$	Savings Accounts	$
Public Assistance	$	$	Checking Accounts	$
Social Security and Disability (Gross)	$	$	Stocks/Bonds	$
Unemployment/ Workers Comp.	$	$	C.D.s	$
Income from annuities, investments, dividends	$	$	Money Market Accts	$
Retirement/Pension	$	$	Home	$
Other Income	$	$	Vehicles	$
Total Income	$	$	**Total Assets**	$

Insurance Information			
Do you have insurance to cover medical expenses? ☐ Yes ☐ No	Have you applied for Medical Assistance? ☐ *Yes* ☐ *No* *If No, you MUST APPLY FIRST*		Are you on a waiting list? ☐ *Yes* ☐ *No* *If yes, attach denial and/or correspondence*
Name of Primary Insurance Company	Effective Date	Policy Number	Group Number
Name of Secondary Insurance Company	Effective Date	Policy Number	Group Number

Read and Sign

I acknowledge that the information on this application is true and correct to the best of my knowledge, and hereby authorize ARMC to release this information to any physician, clinic, and/or other area hospital or clinic to which I am referred. I will notify ARMC of any material changes in the statements provided on this form. I understand that this financial statement is to retain financial assistance and a credit bureau check will be obtained to verify eligibility. It will be treated as confidential information. I also acknowledge that I must enroll in and fully utilize and comply with (1) any Wisconsin Health Care programs that I may qualify for or (2) and medical insurance that may be available to me through an employer and that failure to do so could result in removal from ARMC Financial Assistance Program.

Signature	Date