Children's Hospital of Wisconsin & Children's Specialty Group

Financial Statement- Application for Payment Plan and/or Financial Assistance

Children's Hospital of Wisconsin and Children's Specialty Group offer payment plans and Financial Assistance to those who qualify. Please complete this application in its entirety. **Do not leave any blanks. Please return the application and all supporting documentation within ten days to**:

Children's Hospital of Wisconsin
Patient Accounts MS934
PO BOX 1997
Milwaukee, WI 53201

Copies of the following documents are required and must be submitted with your application:

- Most recent Federal tax return
- Most recent two paycheck stubs for each employer
- Verification of any other source of income.

Children's Hospital of Wisconsin and Children's Specialty Group are separate providers. This form allows you to apply for a payment plan and/or Financial Assistance at each provider. Children's Hospital of Wisconsin and Children's Specialty Group will make independent decisions on payment plans and Financial Assistance.

Patient Name: _____ **Date of Birth:** _____

Account Number: _____

Mother	**Father**
Name:	Name:
Address:	Address:
City, State:	City, State:
Employer:	Employer:
Occupation:	Occupation:
Hourly Rate of Pay: $	Hourly Rate of Pay: $
Net Pay per week/bi-weekly: $	Net Pay per week/bi-weekly: $
Other Income/Source/Amount:	Other Income/Source/Amount:

Total Household Yearly Gross Income: $_____ Total Household Net Monthly Income: $_____

Please turnover sheet to continue.

Assets	Medical Debts
Home Market Value: $	Provider Name/Amount:
Automobile: Year/Make/Model:	
Automobile: Year/Make/Model:	Provider Name/Amount:
Savings Account: $	
Checking Account: $	Provider Name/Amount:
Other Assets:	

Household Debts

Rent/Mortgage Payment/Balance: $	Electric Monthly Payment: $
Car Payment/Balance #1: $	Gas Monthly Payment: $
Car Payment/Balance #2: $	CATV Monthly Payment: $
Other Loan Payment/Balance: $	Telephone Monthly Payment: $
Other Loan Payment/Balance: $	Auto Insurance Payment: $
Credit Card Payment/Balance: $	Child Care Payment: $ week/month
Credit Card Payment/Balance: $	Child Support Payment: $
Credit Card Payment/Balance: $	Other Monthly Payment: $
Credit Card Payment/Balance: $	Other Monthly Payment: $

Total Monthly Payments: $_____ Number of Dependents:____

Proposed Payment Plan: _____

Signed: _____ Date: _____

CHW/CSG Management Use Only

I certify that the above information is complete and accurate. I hereby authorize Children's Hospital of Wisconsin and Children's Specialty Group to release any information necessary for verification of statements made on this application. Furthermore, I hereby authorize release of any information necessary to Children's Hospital of Wisconsin and Children's Specialty Group for the purpose of verification of statements on this application. This consent shall expire six (6) months from the date hereof. This consent is provided pursuant to Section 146.81, WI Statutes. Children's Hospital of Wisconsin and Children's Specialty Group reserve the right to deny any application if it is determined the information has been falsified, is incomplete, or for failure to apply or comply with other applicable assistance programs. Children's Hospital of Wisconsin and Children's Specialty Group determines eligibility for payment plans and Financial Assistance independently.