GRANT REGIONAL HEALTH CENTER

Grant Regional Health Center
507 South Monroe Street
Lancaster, WI 53813
608-723-2143

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Grant Regional Health Center to process your application, all sections must be completed. Also, we need the following supporting documents submitted with your application, if they apply to you:

- Copy of two (2) most recent pay stubs for all household members' employment income
- Most recent bank statements
- Any other statements you receive from income sources (Social Security, alimony/child support, unemployment, retirement/pension, etc.)

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Applicant Name: _____ Date of Birth: ___/___/___
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Email: _____

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card.

☐ Yes ☐ No Insurance Company: _____ Member ID: _____ Group Number: _____

If no, have you applied for Medicaid? ☐ Yes ☐ No

If you have applied for Medicaid, what is the status of your Medicaid application? ☐ Approved ☐ Denied ☐ Pending

Is your service related to an auto accident? ☐ Yes ☐ No

If yes: Insurance Company:_____ Insurance Phone Number:_____ Insurance Policy Number:_____

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.
- For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			

SECTION THREE: INCOME INFORMATION

Provide list any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Wages/Salary		
Self-Employment		
Child Support/Alimony		
Social Security/Retirement		
Rental Income		
Unemployment		
Other Income		

SECTION FOUR: ASSETS INFORMATION
Please list the following

Asset Type	Current Balance - Applicant	Current Balance - Spouse/Other
Bank Account - Savings		
Bank Account - Checking		
Health Savings Account/FSA		

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this medical bill(s). I understand that the information provided may be verified, and I authorize Grant Regional Health Center to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant Grant Regional Health Center permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____

Spouse Signature (if applicable): _____ Date: _____