CHRISTIAN FAMILY SOLUTIONS
Counseling Care & Services

Request for Financial Assistance

Dear Patient and Family:
In keeping with our mission and core values, we are committed to providing health care for people regardless of their ability to pay.

Financial Assistance:
Medical bills may be difficult to pay. Patients who are unable to pay for all or part of their health care services may apply for financial assistance by completing and returning this form. Patients and families who meet certain income requirements may qualify for free care or reduced-price care based on their family size and income, even if they have health insurance. Any determinations to provide free or reduced-price care will be solely in Christian Family Solutions' exclusive judgment.

To view our financial assistance policy and sliding scale guidelines, please go to www.ChristianFamilySolutions.org.

What does financial assistance cover? Financial assistance covers medically necessary services provided by one of our ministries, depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Our financial assistance policies, information about the programs, and application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Here's how to contact us: www.ChristianFamilySolutions.org.

Contact Client Support at:
800.438.1772, option 4 or 262.293.9746
Monday-Friday, 8:00 am to 4:00 pm

In order for your application to be processed, you must provide:

- ☐ **Information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live in the home)
- ☐ **Information about your family's gross monthly income** (all income, from any source, before taxes and deductions)
- ☐ **Declare assets** (as listed on financial assistance application form)
- ☐ **Attach additional information if needed**
- ☐ **Sign and date financial assistance form**

****Income Source Verification Required****
Please submit with your application copies of the following documents:

- ☐ 3 months of employment pay stubs
- ☐ Recent filed tax return for all family members
- ☐ Proof of any other income source as listed on financial assistance application form

Mail completed application with all documentation to *(be sure to keep a copy for yourself)*:
Christian Family Solutions, W175 N11120 Stonewood Dr, Germantown, WI 53022 Attn: FA

To submit your completed application in person:
Take the form to your clinic and hand to a person at the front desk or to your treatment provider.

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Financial Assistance Application Form—confidential

INCOME INFORMATION

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

Income verification is required to determine financial assistance. All family and household members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income.

Please submit with your application copies of the following documents:

- ☐ 3 months of employment pay stubs
- ☐ Recent filed tax return for all family members
- ☐ Proof of any other income source as listed on financial assistance application form

If you have no proof of income or no income, please attach an additional page with an explanation.

_____ # of family members in your household *(family includes people related by birth, marriage, or adoption who live in the home)*

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $________________________ Medical expenses $________________________

Insurance premiums $________________________ Utilities $________________________

Other debt/expenses $________________________ *(child support, loans, medications, other)*

ASSET INFORMATION

This information may be used if your income is above 200% of the Federal Poverty Guidelines.

Current checking account balance $______________________________ Current savings account balance $______________________________	Does your family have any of these other assets? Please check all that apply and include amounts for each on an additional page: ☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account(s) ☐ Trust(s) ☐ Property (excluding primary residence) ☐ Own a business

ADDITIONAL INFORMATION

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.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

Patient Name ____ DOB ________________________

Acknowledgment

By signing this form, I represent and warrant that the above information is true and correct and accurately reflects my financial condition and the resources that are available to pay for my care and/or services. I understand that Christian Family Solutions will be relying on the information provided herein and may deny any financial assistance and terminate any and all services to me if I provide false or misleading information. I further give Christian Family Solutions permission to verify the information provided herein. I also understand that I may be required to provide supporting documentation regarding the financial data I have provided and provide updated financial information, and I agree to do so upon request.

____ ____________________________

Printed name of applicant Relationship to patient

____ ____________________________

Signature of applicant Today's date