Financial Assistance Application

Black River Memorial Hospital, Inc., gives a reasonable amount of its services, without charge to eligible persons who cannot afford to pay for care.

To be eligible to receive financial assistance or discounted care, your family income must be at or below the following levels:

Size of Family	Income Guidelines at 275%	Income Guidelines at 300%
1	$33,385.00	$36,420.00
2	$45,265.00	$49,380.00
3	$57,145.00	$62,340.00
4	$69,025.00	$75,300.00
5	$80,905.00	$88,260.00
6	$92,785.00	$101,220.00
7	$104,665.00	$114,180.00
8	$116,545.00	$127,140.00
For each additional person, add:	$11,880.00	$12,960.00

1. Black River Memorial Hospital will assist you in identifying program and insurance options available to you.

2. Black River Memorial Hospital requires that this application be returned by the assigned due date.

If you think you may be eligible for financial assistance services, please contact a Patient Financial Advocate at 715-284-1368 or 715-284-3691. Black River Memorial Hospital, will make a written conditional or final determination of your eligibility for financial assistance or discounted services.

To fax an advocate: 715-284-3630 or 715-284-3639.

Patient Financial Advocates are available by appointment only.

Income guidelines are based on up to 300% of 2018 Health and Human Services poverty guidelines.

If receiving your financial assistance application by mail, please contact a patient financial advocate once you receive your application.

Financial Assistance Application

Date:_____ Name: _____

Medical Record No: _____ Hospital Encounter Number: _____

The requested information below will help us assess your financial situation and determine your ability to pay for services provided by Black River Memorial Hospital. **NOTE:** until your financial assistance application has been reviewed and approved by our financial assistance team, you will be financially responsible for your medical bills.

In addition to the completion of this financial assistance application, the following documentation may be required:

- ☐ A complete copy of Federal and State Income Tax Returns including any schedules
- ☐ Pay Stub(s) or other written form of income verification for the last 30 days
- ☐ A written copy of a Medical Assistance Determination from your local county
  For additional information on how to apply for medical assistance, please contact a representative at 1-888-627-0430 (Wisconsin).
- ☐ A letter explaining current financial situation. If you do not have income and you reside with someone or you have someone helping you with your living expenses, please have that person write a brief note stating the current arrangement surrounding your residency. This note needs to be signed and dated.
- ☐ Copy of your mortgage balance statement for all properties owned
- ☐ Copy of your property taxes for all property, including rental, farm land and primary residence
- ☐ Any other verification, such as bank statements, etc. per application below
- ☐ Signed and completed Financial Assistance Application
- ☐ Other coverage
  - o Are you seeking Financial Assistance because of a work-related accident or injury?
  - o Are you seeking Financial Assistance because of a motor vehicle accident?
  - o Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury?

***Your application for financial assistance may require additional documentation.**

Your completed application due date is: _____

PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION

Primary Applicant:

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Phone Number: (_____) _____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Financial Assistance Application

Secondary Applicant:

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Phone Number: (_____) _____ Social Security Number: _____

Number of dependents under 18 currently claimed on your taxes: _____

☐ Children _____ ☐ Stepchildren _____ ☐ Other/Relationship _____

Employment information of applicant:
If you are considered self-employed, please include bank statements for the past 60 days. If you are unable to work due to medical conditions and have not already been approved for Security Disability Income, please provide written verification that you have applied for SSDI and the current status.

Primary Applicant

Employer _____

City/State _____

Phone _____

Occupation/Hire Date _____

Gross Monthly Salary _____

Primary Applicants Additional Source of Income:

Other Wages	$ _____
Interest, Dividends	$ _____
Rental Income	$ _____
Food Stamps	$ _____
Alimony	$ _____
Child Support	$ _____
Pension	$ _____
Worker's Compensation	$ _____
Unemployment	$ _____
Farm Income	$ _____
Self-Employment	$ _____
SSI/Social Security	$ _____
Veterans Benefits	$ _____
Other	$ _____
TOTAL	$ 0.00

Secondary Applicant

Employer _____

City/State _____

Phone _____

Occupation/Hire Date _____

Gross Monthly Salary _____

Primary Applicants Additional Source of Income:

Other Wages	$ _____
Interest, Dividends	$ _____
Rental Income	$ _____
Food Stamps	$ _____
Alimony	$ _____
Child Support	$ _____
Pension	$ _____
Worker's Compensation	$ _____
Unemployment	$ _____
Farm Income	$ _____
Self-Employment	$ _____
SSI/Social Security	$ _____
Veterans Benefits	$ _____
Other	$ _____
TOTAL	$ 0.00

If you list additional income above, please provide written verification of that income for the past 30 days.

Financial Assistance Application

Property: (if no mortgage or rent, please explain why)

Residence: ☐ Own ☐ Rent $_____

	Monthly Payments	Estimated Value	Unpaid Balance
1st Mortgage	$	$	$
2nd Mortgage	$	$	$
Other Real Estate	$	$	$

Assets: (if you indicate a balance, please provide a complete copy of written verification of the current balance)

Checking Balance	$	Savings Balance	$
Health Savings Account/FLEX	$	Other Assets	$

Liabilities:

Credit Cards and Loans (please provide a copy of current statements).

Medical and Dental Bills (please provide a copy of current statements).

I authorize Black River Memorial Hospital to verify any information given on this financial statement. I attest that the above information is accurate to the best of my knowledge and truly represents my current financial status. This financial information, along with information obtained through the verification process, will only be used for the sole purpose of determining if the services received would be provided at a discounted rate.

Applicant Signature: _____ Spouse Signature: _____

Date: _____ Date: _____