Black River MEMORIAL HOSPITAL

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. No one will be denied access to services due to inability to pay.

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

FAMILY SIZE – HOUSEHOLD INCOME

% of FPG	Discount	1	2	3	4	5	6	7	8
100%	100%	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	$47,340	$52,720
125%	100%	$18,825	$25,550	$32,275	$39,000	$45,725	$52,450	$59,175	$65,900
130%	100%	$19,578	$26,572	$33,566	$40,560	$47,554	$54,548	$61,542	$68,536
135%	100%	$20,331	$27,594	$34,857	$42,120	$49,383	$56,646	$63,909	$71,172
150%	100%	$22,590	$30,660	$38.730	$46,800	$54,870	$62,940	$71,010	$79,080
175%	100%	$26,355	$35,770	$45,185	$54,600	$64,015	$73,430	$82,845	$92,260
180%	100%	$27,108	$36,792	$46,476	$56,160	$65,844	$75,528	$85,212	$94,896
185%	100%	$27,861	$37,814	$47,767	$57,720	$67,673	$77,626	$87,579	$97,532
200%	100%	$30,120	$40,880	$51,640	$62,400	$73,160	$83,920	$94,680	$105,440
225%	75%	$33,885	$45,990	$58,095	$70,200	$82,305	$94,410	$106,515	$118,620
250%	75%	$37,650	$51,100	$64,550	$78,000	$91,450	$104,900	$118,350	$131,800
275%	75%	$41,415	$56,210	$71,005	$85,800	$100,595	$115,390	$130,185	$144,980
300%	50%	$45,180	$61,320	$77,460	$93,600	$109,740	$125,880	$142,020	$158,160
325%	25%	$48,945	$66,430	$83,915	$101,400	$118,885	$136,370	$153,855	$171,340
350%	25%	$52,710	$71,540	$90,370	$109,200	$128,030	$146,860	$165,690	$184,520
375%	10%	$56,475	$76,650	$96,825	$117,000	$137,175	$157,350	$177,525	$197,700
400%	10%	$60,240	$81,760	$103,280	$124,800	$146,320	$167,840	$189,360	$210,880

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 400% of 2024 Federal Poverty Guidelines.

Please complete, sign, and return the application within 10 business days.

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Patient Name: ______________________________________ Date of Birth: __________________________

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.

For additional information on how to apply for medical assistance, please contact a representative at 1-888-627-0430 (Wisconsin).

In addition to the completion of this financial assistance application, the following documentation may be required. If you are unable to provide any of the information required, please indicate the reason on the comment line given. No one will be denied emergency and other non-elective services due to their inability to pay.

1. Pay Stub(s) or other written form of income verification for the last 30 days.
   - ☐ If unable to provide, please explain:____
2. A copy of your current bank statement.
3. Please check any that may apply:
   - ☐ Are you seeking Financial Assistance because of a work-related accident or injury?
   - ☐ Are you seeking Financial Assistance because of a motor vehicle accident?
   - ☐ Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury?

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***Your application for Financial Assistance may require additional documentation.**

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: ______________________________________

Please list all household members, including those under age 18.

Full Name	Relationship	Birth Date

If you have more dependents than the space that is provided, please use a separate page.

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 _________________________________

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Source of Income	**Primary Applicant**	**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	$	$
Percapita Income	$	$
Total	**$**	**$**

If you list additional income above, please provide written verification of that income for the past 30 days.
Payroll stubs must include year-to-date earnings.

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: ____ Date: ____________________