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.

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%	$14,580	$19,720	$24,860	$30,0000	$35,140	$40,280	$45,420	$50,560
125%	100%	$18,225	$24,650	$31,075	$37,500	$43,925	$50,350	$56,775	$63,200
130%	100%	$18,954	$25,636	$32,318	$39,000	$45,682	$52,364	$59,046	$65,728
135%	100%	$19,683	$26,622	$33,561	$40,500	$47,439	$54,378	$61,317	$68,256
150%	100%	$21,870	$29,580	$37,290	$45,000	$52,710	$60,420	$68,130	$75,840
175%	100%	$25,515	$34,510	$43,505	$52,500	$61,495	$70,490	$79,485	$88,480
180%	100%	$26,244	$35,496	$44,748	$54,000	$63,252	$72,504	$81,756	$91,008
185%	100%	$26,973	$36,482	$45,991	$55,500	$65,009	$74,518	$84,027	$93,536
200%	100%	$29,160	$39,440	$49,720	$60,000	$70,280	$80,560	$90,840	$101,120
225%	75%	$32,805	$44,370	$55,935	$67,500	$79,065	$90,630	$102,195	$113,760
250%	75%	$36,450	$49,300	$62,150	$75,000	$87,850	$100,700	$113,550	$126,400
275%	75%	$40,095	$54,230	$68,385	$82,500	$96,635	$110,770	$124,905	$139,040
300%	50%	$43,740	$59,160	$74,580	$90,000	$105,420	$120,840	$136,260	$151,680
325%	25%	$47,385	$64,090	$80,795	$97,500	$114,205	$130,910	$147,615	$164,320
350%	25%	$51,030	$69,020	$87,010	$105,000	$122,990	$140,980	$158,970	$176,960
375%	10%	$54,675	$73,950	$93,225	$112,500	$131,775	$151,050	$170,325	$189,600
400%	10%	$58,320	$78,880	$99,440	$120,000	$140,560	$161,120	$181,680	$202,240

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 2023 Federal Poverty Guidelines.

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

FINANCIAL ASSISTANCE APPLICATION

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.

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.

1. Do you file income taxes?

   ☐ Yes – Please attach a copy of the most recent tax documents. if you do not have a copy, you can request one by calling 1-800-908-9946 or by going online to

   http://www.irs.gov/Individuals/Get-Transcript

   ☐ No – Please explain: _____

2. Pay Stub(s) or other written form of income verification for the last 30 days.

   ☐ If unable to provide, please explain:_____

3. 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).

   I have applied or will be applying

   ☐ Yes
   ☐ No – Not a U.S. Citizen
   ☐ No – Over Income
   ☐ Other Reason – Please explain: _____

4. A letter explaining your 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 residence. This note needs to be signed and dated.
5. Copy of all mortgage balances and property taxes for all properties owned
6. A copy of your current bank statement, a list of all household bills, i.e.-phone, heat, electric, etc.
7. Please check any that may apply:
   ☐ Medical Assistance eligible, not effective prior to the date of service
   ☐ Homeless – Please explain: _____
   ☐ Deceased, no estate
   ☐ Incarcerated
   ☐ Other coverage
      ☐ 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?

FINANCIAL ASSISTANCE APPLICATION

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

PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION

Responsible Party:

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Phone Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse/Co-Guarantor:

Name: _____ Date of Birth: _____
Last First MI

Address: _____
Street City State Zip

Phone Number: _____

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

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 _____
Gross Monthly Salary _____

Spouse/Co-Guarantor

Employer _____
City/State _____
Phone _____
Occupation/Hire Date _____
Gross Monthly Salary _____

Black River MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Primary Applicant - 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	$
Per Capita Income	$
TOTAL	$ 0.00

Spouse/Partner - 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	$
Per Capita Income	$
TOTAL	$ 0.00

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.

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: _____