Financial Assistance Application

Dear Patient:

IMPORTANT – YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Agnesian HealthCare determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please complete this form in its entirety, including signature and date of completion. Submit the application with all requested supporting documentation in-person, by mail or by fax.

This serves as the application for hospital, clinic, lab and pharmacy financial assistance.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security number is required for some public programs, including Medicaid. While providing a Social Security number is not required, it will help the hospital determine whether you qualify for any public programs.

Please note: Agnesian HealthCare will not be able to determine eligibility without proper documentation. Please ensure that you have assembled all the required documents. Failure to send all required documents will result in a delay processing your application. Please note checklist on page two.

Please send in unaltered and unstapled copies of your documentation. Agnesian HealthCare is unable to return original documents being considered for financial assistance.

Patients deemed eligible for presumptive charity must still complete this application.

If you need help completing your application or have any questions, contact us at (920) 926-4841.

Agnesian HealthCare Community Care
430 E. Division Street
Fond du Lac, WI 54935
Phone: (920) 926-4841
Fax: (920) 926-8874

AGNESIAN HEALTHCARE

A member of SSMHealth

Applicant	Spouse	
		INSURANCE INFORMATION FROM YOU AND YOUR SPOUSE
❑	❑	• Those whose monthly income is below 100% of federal poverty level and have no insurance must first apply for BadgerCare Plus and submit a BadgerCare Plus determination within 30 days of submitting your Financial Assistance Program application. BadgerCare Plus applications are available online at access.wi.gov or by calling (800) 362-3002.
		INCOME INFORMATION FOR YOU AND YOUR SPOUSE
		In addition to filling out the information related to income on the application, we also need copies of any of the following that apply to your situation. Bank statements are not proof of income. Proof for all sources of income must be provided and include a gross pay total on the document.
❑	❑	• Copy of most recent payroll stubs for the last 2 months.
❑	❑	• Disability payment (short-term/long-term from employer).
❑	❑	• Social Security statement of current amount received.
❑	❑	• Copy of unemployment compensation for the last 2 months.
❑	❑	• Copy of child support/maintenance payments (examples are support agreement or statement of payments for the last 2 months).
❑	❑	• Copy of pension payments and other retirement compensation for the last 2 months.
		FEDERAL TAX RETURN FOR YOU AND YOUR SPOUSE
❑	❑	• Copy of your most current filed federal income tax (1040) including all forms and schedules.
❑	❑	• If you did not file or are unable to locate your current federal tax return, you will need to supply a non-filing letter or IRS transcript. You can request a federal non-filing letter or IRS transcript online at www.irs.gov. Click on “get my tax record.” Select whether to get your transcript online or by mail. Follow the instructions for completing your request.
❑	❑	• If you were claimed as a dependent on another person’s federal income tax, a copy of the individual’s federal filed income tax (1040).
		ASSET INFORMATION FOR YOU AND YOUR SPOUSE (May be required.)
❑	❑	• Copy of your most recent 3 months of bank statements (savings and checking) and debit card transactions. Include all pages even if blank or little information.
❑	❑	• Copy of your most recent 3 months of business bank statements if self-employed.
❑	❑	• Attestation of income and support and other evidence to support financial need.

SSM Health

APPLICATION FOR FINANCIAL ASSISTANCE

Wisconsin
- ☐ SSM St. Clare Hospital
- ☐ SSM St. Mary's Hospital (Madison)
- ☐ SSM St. Mary's Janesville Hospital
- ☐ St. Agnes Hospital
- ☐ Waupun Memorial Hospital
- ☐ Ripon Medical Center

Missouri
- ☐ SSM St. Francis Hospital
- ☐ SSM Health St. Mary's Hospital - Audrain
- ☐ SSM Health St. Mary's Hospital - Jefferson City
- ☐ SSM Cardinal Glennon Children's Medical Center
- ☐ SSM DePaul Health Center
- ☐ SSM St. Louis University Hospital

Missouri
- ☐ SSM St. Clare Health Center
- ☐ SSM St. Mary's Health Center
- ☐ SSM St. Joseph Health Center
- ☐ SSM St. Joseph Hospital West – Lake St. Louis
- ☐ SSM St. Joseph Health Center – Wentzville

Oklahoma
- ☐ SSM Bone & Joint Hospital at St. Anthony
- ☐ SSM St. Anthony Hospital – Oklahoma City
- ☐ SSM St. Anthony Hospital – Shawnee

Illinois
- ☐ SSM Good Samaritan Hospital - Mt. Vernon
- ☐ SSM St. Mary's Hospital - Centralia

Guarantor ID: ____________________
(for office use only)

ALL fields must be completed for application to be processed; indicate N/A on all fields that do not apply.

PATIENT INFORMATION

Patient Name:		DOB	Telephone Number	Patient Account #	
Current Street Address:		Apt #	City/State/Zip	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced	Family Size: (Complete Household Section Below)
Social Security Number: ☐ No Social Security Number	Insured: ☐ Yes ☐ No	Have you applied for Medicaid: ☐ Yes* ☐ No *Please include determination letter	Employed: ☐Yes ☐No Self Employed: ☐Yes ☐No Years Employed:	Employer: If unemployed, name of last employer and dates worked:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Guarantor Name:		DOB	Telephone Number	Patient Account #	
Current Street Address:		Apt #	City/State/Zip	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced	Family Size: (Complete Household Section Below)
Social Security Number: ☐ No Social Security Number	Insured: ☐ Yes ☐ No	Have you applied for Medicaid: ☐ Yes* ☐ No *Please include determination letter	Employed: ☐Yes ☐No Self Employed: ☐Yes ☐No Years Employed:	Employer: If unemployed, name of last employer and dates worked:	

HOUSEHOLD INFORMATION

Please attach a separate sheet for additional household members, including all required documents.

First & Last Name	Relationship	DOB SSN?: Yes/No	Employed - Proof Required	Full Time Student? Proof Required	Gross Monthly Income if 18 or over - Check all applicable forms of income and indicate total amount received from all sources. (Documentation for each income source required)
	SELF	☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐Yes ☐No	☐Yes ☐No Student Visa? ☐Yes ☐No	☐Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other

Please provide proof of gross income for all household members age 18 or over for the following: (including but not limited to): wages, social security (award letter), pension(s), unemployment/workman's compensation, alimony/child support, government assistance, disability payments, strike benefits, scholarships/grants, dividends/interest, rental income, cash for services, etc. International students will need to submit student visa and current school schedule. **Bank statements are not verification/proof of income.**

Please note: Depending on the circumstances of your application, we may require additional documents (such as, but not limited to: bank statements, household bills, medical bills, Attestation of Income and Support, credit reports, and other evidence to support financial need).

SSMHealth

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Guarantor ID: ____________________

HOUSEHOLD ASSETS**

Only check boxes if no household members have selected assets(s)

Family Member Name	Checking Account(s) Bank Name	Acct Number and Balance	Savings Account(s) Bank Name	Acct Number and Balance	Other (IRA, CD, Etc.)	Balance
	☐Personal ☐Business		☐Personal ☐Business			
	☐Personal ☐Business		☐Personal ☐Business			
	☐Personal ☐Business		☐Personal ☐Business			
Check if no household members have:	☐No Checking Account(s)		☐No Savings Account(s)		☐No Other Form(s) of Liquid Asset(s)	

Family Member Name	Health Savings/Flex Spending Account (value)	Vehicle (Year/Make/Model)	Vehicle Value	Real Estate Owned (Indicate type - primary residence, rental, etc.) and Purchase Price	Current Loan Balance	Any Other Asset(s) and Value
		☐Business Vehicle		Purchase Price:		Asset: Value:
		☐Business Vehicle		Purchase Price:		Asset: Value:
		☐Business Vehicle		Purchase Price:		Asset: Value:
Check if no household members have:	☐No HSA/Flex Account	☐No household vehicle		☐No Real Estate *If no Real Estate Owned, please indicate if you: ☐Rent ☐ Live with parent(s)/other supporter		☐None

Attach a separate sheet for additional asset information.

HOUSEHOLD LIABILITIES**

Expense	Monthly	Balance Due
Housing		
Utilities		
Food		
Transportation		
Child Care		
Loans		
Medical Expenses		
Other Expenses (List)		
Other:		

Attach a separate sheet for additional liability information. ***Patients Receiving Care in Illinois Hospitals Only: If patient meets the presumptive eligibility criteria described in 77 ILAC 4500.40 or is otherwise presumptively eligible by virtue of family income, the patient is not required to complete this section of the application****

***** Patients receiving care from an SSM Rural Health Clinic/National Health Service Corps member site, are not required to complete this section of the application*****

PATIENT AGREEMENT

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 hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital 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 hospital bill.

____ ____

Patient Signature **Date** **Spouse Signature (or Responsible Party)** **Date**

Preferred Method of Contact: ☐ Phone: (____) ______-__________ ☐ E-mail: ______________________________ ☐ Other: ____________________________