

### Dear Applicant:

The mission of Beloit Health System is to be the leader in regional health and wellness services that delivers high quality value and satisfaction to our patients and communities we serve. Beloit Health System is committed to provide services to those who qualify but are unable to pay and those whose limited means make it extremely difficult to meet the expenses incurred in receiving healthcare. If you qualify for reduced fees or extended payment plans, we ask that you honor any payments established.

If you need assistance with the application process, please call (608)364-5584 or (608)364-5585 or for long distance: 1-800-846-1150 and ask for assistance from a Credit Consultant.

### **Criteria for Financial Assistance Eligibility:**

- Before any financial assistance is granted, you must have exhausted all other sources of payment, including insurance, public assistance, litigation, or third-party liability.
- You family income, in relation to Federal Poverty Guidelines will be considered.
- Your assets (e.g. home, bank account, stocks, etc.) must be disclosed to us.
- Any additional financial hardship should be disclosed to us.
- You must be receiving non-elective, medically necessary care.
- You must consult with one of Beloit Health System's Credit Consultants.
- Your application must be received within 240 days of the service date.
- You must be a resident of our service area, certain limited exceptions may apply.

#### **How to Apply for Financial Assistance**

You must complete the Financial Application in its entirety. You must also include:

Copy of Federal Income Tax Return for the most recent tax year, including all schedules filed with the original return.
Copy of most recent income information for each person in the household, including: last year's W-2 forms, two most recent
paycheck stubs or a statement from the employer, Social Security, unemployment, retirement, pensions, support payments
etc.
If self-employed, copy of most recent Federal Income Tax Return and all supporting documents.
Copies of two most recent financial statements (savings, checking, money market, IRA, 401k, brokerage, etc.).
Copy of food stamp or Heat Assistance benefit(s).
If the household is receiving assistance from family or friends, a statement from the assisting party.
If you qualify for Social Security Disability, you must provide documentation that the application is being processed.
Verification that you have applied for all medical-related resources:
Medical Assistance/Family Planning
<ul><li>Rock County (888)794-5780</li></ul>
<ul><li>Winnebago County (815)987-7620</li></ul>
<ul><li>Wisconsin Well Woman Program</li></ul>
Provides preventive health screening services to women with little or no health insurance coverage. 608-266-8311
Denial and appeal documentation from any liability insurance, if involved in an accident or assault.
If you are a college student, you must supply documentation of current student status.

### In order for your applications to be considered, you must submit all applicable above listed items.

Please return the completed form and supporting documents to:

Beloit Health System Attention: Financial Counselors 1969 West Hart Road Beloit WI 53511

Thank you for your interest in Beloit Health System's Financial Assistance program.



# **FINANCIAL APPLICATION**

APPLICANT LAST NAME  PATIENT FIRST NAME  MI SOCIAL SECURITY NUMBER  STREET ADDRESS  CITY STATE  DATE OF BIRTH  ZIP  TELEPHONE – HOME  TELEPHONE – WORK  TELEPHONE – CELL  E-MAIL ADDRESS  SPOUSE'S NAME  SPOUSE'S DATE OF BIRTH  DENTIFY AND LIST NUMBER OF DEPENDENTS AS SHOWN ON TAX RETURN:  FAMILY STATUS: LIST ALL DEPENDENTS THAT YOU SUPPORT  NAME  AGE  RELATIONSHIP TO APPLICANT  SPOUSE  EMPLOYMENT STATUS: (CHECK BOX)  PULL TIME PART TIME SELF-EMPLOYED  UNEMPLOYED RETIRED OTHER  IF EMPLOYED ADDRESS:  EMPLOYER NAME:  EMPLOYER ADDRESS:  EMPLOYER NAME:  EMPLOYER NAME:  EMPLOYER PHONE:  OCCUPATION:  DATE OF MELL TIME PROPESS:  EMPLOYER PHONE:  OCCUPATION:  DATE OF MELL TIME PROPESS:  EMPLOYER PHONE:  OCCUPATION:  DATE OF MELL TIME PROPESS:  EMPLOYER NAME:  EMPLOYER PHONE:  OCCUPATION:  DATE OF MELL TIME PROPESS:  EMPLOYER SELF-EMPLOYED  IF YES, DID YOU RECEIVE THIS INSURANCE?  IF YES, DID YOU RECEIVE THIS INSURANCE?  IF YES, DID YOU RECEIVE THIS INSURANCE, REASON WHY  IF YES, DID YOU RECEIVE THIS INSURANCE, REASON WHY  IF YES, DID YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY  IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY	GENERAL INFORMATION				
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Revised: 06/2016



# **FINANCIAL APPLICATION**

DATE UNEMPLOYED	DATE UNEMPLOYED
REASON FOR UNEMPLOYMENT	REASON FOR UNEMPLOYMENT

MONTHLY INCOME: PLEAS	E LIST ALL SOURC	ES OF INCOME ON A MONTHLY BASIS *	
APPLICANT NET SALARY	\$	WORKERS COMPENSATION	\$
SPOUSE NET SALARY	\$	UNEMPLOYMENT	\$
RENTAL INCOME	\$	SICK/DISABILITY PAY	\$
FOOD STAMPS	\$	SOCIAL SECURITY	\$
PENSION/RETIREMENT	\$	SUPPORT OR ALIMONY	\$
SSI/SSD	\$	INTEREST AND DIVIDENDS	\$
BUSINESS INCOME	\$	OTHER INCOME	\$

\*You must provide proof of income.

If no source(s) of Income, how have you been supporting yourself?
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ASSETS		
ACCOUNT TYPE	NAME OF BANK/S&L/CUSTODIAN	CURRENT BALANCE/VALUE
CHECKING		\$
SAVINGS		\$
HOME		\$
LIFE INSUANCE (CASH VALUE)		\$
401-K, IRA, TSA, AND OTHER RETIREMENT PLAN		\$
STOCKS/BONDS/MUTUAL FUNDS (CASH VALUE)		\$
CD'S		\$
PROPERTY OTHER THAN HOME (LAND, RENTAL PROPERTY, ETC.)		\$
CASH ON HAND (NOT IN BANK)		\$
AUTO(S) / BOATS / MOTORIZED RECREATION VEHICLES	MAKE/TYPE/YEAR	\$ \$ \$
OTHER ASSETS		\$

Revised: 06/2016



# **FINANCIAL APPLICATION**

EXPENSE		OUTSTANDING BALANCE		MONTHLY PAYMENT
ENT OR MORTGAGE	\$			\$
AUTO LOAN(S)	\$			\$
OTHER LOANS	\$			\$
JIIILN LOANS	·			•
	\$			\$
OTHER MONTHLY EXPENSES:				
CHILD SUPPORT \$		FOOD \$		DICINE IARMACY \$
OTHER COURT ORDERED \$		GASOLINE /TRANSPORTATION \$	ОТІ	HER\$
JTILITIES: GAS/ FUEL /ELECTRI SEWER /WATER \$	IC	TELEPHONE/ CELL PHONE \$	ОТІ	HER\$
NSURANCE PREMIUM(S) \$		SCHOOL EXPENSES \$	ОТІ	HER \$
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