Ascension

Enclosed please find a Financial Assistance Application.

Guided by the mission and values of Ascension Wisconsin, Financial Assistance is available to eligible patients who are unable to pay all or part of their health care expenses. Ascension Wisconsin has established eligibility guidelines for our Financial Assistance Program. Approval of Financial Assistance will be considered for all patients who meet the program criteria.

The Financial Assistance Program should be your last resort. Payment from all other sources should be exhausted before eligibility for this program can be considered, including application for Medicaid or other public assistance programs.

Please return the completed application along with the necessary information on the enclosed checklist within 30 days. In order to consider you for Financial Assistance, all the documents listed on the checklist must be provided. If you cannot provide any of the requested documentation, please indicate the reason(s).

A determination letter for Financial Assistance will be sent within 45 business days after your completed application has been received.

If you have any questions or need assistance in completing the application, please call your local business office.

Sincerely,
Ascension Wisconsin

Ascension Wisconsin
855.642.2455 option 1

Ascension Medical Group
Ascension Calumet Hospital
Ascension Mercy Hospital
Ascension St. Elizabeth Hospital
866.832.1120 option 1

Mail application to:

Ascension St Michael's Hospital
Attn: Financial Counseling
900 Illinois Ave
Stevens Point, WI 54481

Financial Assistance Documentation Checklist

Patient Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Account Number _____ Account Number _____

Account Number _____ Account Number _____

The following information needs to be returned with your completed application.

Attach a copy of your most recent Federal and State tax return. If you do not have a copy of your taxes you may call 800.829.1040 and choose the option to receive a transcript. Please follow the phone instructions carefully. This will be sent free of charge. If you have not filed taxes please complete Form 4506-T and return with your Financial Assistance application.

Attach a **copy** of your W2's, 1099, schedules and attachments for the same year of the tax return for each employer.

Attach a **copy** of your two most recent pay stubs for each employer showing gross earnings. **** If no income, please explain how you provide for your living expenses.**

Attach a **copy** of your two most recent monthly personal and business bank statements for each account, including all pages showing all transactions.

Attach a **copy** of your Social Security benefit letter.

Attach a **copy** of your documentation of any Unemployment received in the past 12 months. You may call the Department of Workforce Development at 608-232-0678 or visit https://dwd.wi.gov/ui/ to request a statement.

Please provide a **copy** of your most recent Wisconsin Medicaid Determination Letter and/or proof that you applied at the Health Insurance Exchange. Premiums are required to be paid and up to date or this application may be denied.

Other: _____

Please sign and date the enclosed Financial Assistance Application.

Patient's Name _____ Date _____

Medical Record #or Date of Birth _____

Street Address _____

Telephone (with area code) _____ County _____

Have you applied at any other Ascension Wisconsin recently? Yes No

If yes, where? _____

Responsible Party Name _____
Mother Father Self Other

City _____ State _____ Zip Code _____

Telephone (with area code) _____ County _____

Household Members Name/Relationship/Date of Birth _____

_____

_____

Demographic Information

Responsible Party

Social Security Number _____

Employer _____

Business Address _____

Business Phone _____

Occupation _____

Length of Employment _____

Hourly Wage _____ Hours Worked _____

Spouse (If applicable)

Social Security Number _____

Employer _____

Business Address _____

Business Phone _____

Occupation _____

Length of Employment _____

Hourly Wage _____ Hours Worked _____

Income Sources – Monthly Gross (Before Taxes)

Documentation of ALL income must be provided with your application. Failure to provide documentation may result in a denial of Financial Assistance.

Responsible Party		Spouse (If applicable)	
Monthly Gross (Before taxes)	$	Monthly Gross (Before taxes)	$
Social Security	$	Social Security	$
Public Assistance	$	Public Assistance	$
Rental Income	$	Rental Income	$
Retirement/Pension	$	Retirement/Pension	$
Veterans Benefit	$	Veterans Benefit	$
Are you a Veteran or entitled to Veterans Benefits?	Yes No	Are you a Veteran or entitled to Veterans Benefits?	Yes No
Unemployment/ Workers Compensation	$	Unemployment/ Workers Compensation	$
From ____ To ____		From ____ To ____	
Alimony	$	Alimony	$
Disability	$	Disability	$
Other	$	Other	$
Total	$	Total	$

TOTAL Combined Monthly Gross Income $ _____

If zero or no income, please explain how you provide for your living expenses: _____

Assets/Savings

Checking Account(s)	
Bank Location:	Amount/Value $
Bank Location:	Amount/Value $
Savings Account(s)	
Bank Location:	Amount/Value $
Bank Location:	Amount/Value $

Monthly Expenses

Mortgage	Rent	Utilities	Phone	Medications	Child Care
$	$	$	$	$	$
Child Support	**Alimony/Support**	**Property Taxes**	**Auto (Gas/Repairs)**	**Auto Insurance**	**Health Insurance**
$	$	$	$	$	$
Auto Loan	**Other**	**Other**	**Other**	**Other**	**Other**
$	$	$	$	$	$

TOTAL $ _____

Charge Accounts & Other Expenses

Creditor Name	Balance $	Payment $

TOTAL $_____

Medical Expenses

Creditor Name	Balance $	Payment $

TOTAL $_____

TOTAL Combined Expenses $_____ (monthly, charge accounts, medical and other)

Have you applied for any state/county assistance program/healthcare.gov? Yes No

If yes, Program _____ County _____

Date Applied _____ Application: Accepted Denied Pending **Proof Required

I attest that the above information is true to the best of my knowledge and I authorize Ascension Wisconsin to verify any information for their confidential use in determining my ability to pay for medical services. Providing false information will void this application.

Responsible Party's Signature _____ Relationship _____ Date _____

Note: If all required documentation is not enclosed, application may not be considered. Additional information may be requested upon review of the application.