Guarantor Account Number:_____

Brown County Hospital
Financial Assistance Application

SECTION I: PERSONAL INFORMATION

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Family/Household Member First and Last Name	Dependent (Yes)/(No)	Relationship	DOB	SSN
1				
2				
3				
4				
5				

Employment

Applicant's Employer Name	Applicant's Employer Address	Job Title	Employer Phone Number

Spouse's Employer Name	Spouse's Employer Address	Job Title	Employer Phone Number

Current Medical Insurance Coverage

Name of plan(s): _____

Parties covered by the plan(s): _____

Per BCH financial assistance policy, applicants are to be compliant with the Affordable Care Act which generally requires parties to have medical insurance coverage. Therefore, if there is no medical insurance coverage for yourself, spouse and/or dependents , please provide the following additional information in order for your application to be considered.

Does applicant's employer provide medical insurance coverage: Y / N If Y, explain why applicant & dependents do not participate in the plan?

_____

_____

If employer does not provide health coverage, have you applied for health insurance via commercial market or healthcare.gov? Y / N

If Y, name of insurance and date applied: _____

If N, provide explanation below as to why you opted not to carry health insurance

1)

Other Information

Have you filed for: (Yes/No) Disability: _____ Medicaid: _____ WIC: _____ Supplement Benefits/Food Stamps: _____

If Yes, indicate dates:

SECTION II: ASSETS

Cash and Investments

Cash on Hand & Checking Account Balance	$	Brown County Hospital does not take into consideration your home or
Savings Account Balance	$	automobiles. Any additional resources, please list below: (i.e. boat, trailer)
Investments	$	Description of asset: Value of asset:
Retirement Accounts	$	$
Other: _____	$	$

Total Cash and Investments: $_____

Guarantor Account Number:_____

SECTION III: INCOME VERIFICATION
supporting documents must accompany the application

REQUIRED: (for you, spouse, and dependents)		copies attached? Y/N	If N, explain
1	Most current filed Income Tax Return including schedules and copies of W-2s		
2	If employed, most recent pay stub(s)		
3	Social Security Benefit Letter (if applicable)		
4	Most recent 3 months of bank statements		
5	Current copies of all investments (i.e., savings, money market, pensions, 401(k) accounts) Note - if currently contributing or have contributed to a retirement fund (pension, 401k, etc.) most recent statements are required		
6	If uninsured, correspondence from insurance companies, Healthcare.gov or SSI Disability Determination letter		
7	Most recent unemployment check (if receiving unemployment)		

SECTION III: INCOME AMOUNTS
based on gross income, not taxable income

Source of Income:	Applicant Monthly Gross	Spouse Monthly Gross
Salary/Wages	$	$
Salary/Wages		
Salary/Wages		
Social Security Benefits		
Pension Payments		
Unemployment		
Self -Employment Income		
Other - Please Specify:		
_____		
Total Monthly Income:	**$**	**$**

*** The amounts listed are guidelines, exceptions to income limits may be permitted based on individual need & circumstances**

SECTION IV: APPLICANT STATEMENT & REASON FOR REQUEST

Brown County Hospital's Financial Assistance Policy is to provide financial assistance to the poor and financially disadvantaged, within the available resources of the Hospital (based on income guidelines as outlined in Section III). Financial assistance is a resource of last resort and is only available when all other recovery sources have been exhausted; and is provided to patients with demonstrated inability to pay.

Please provide a description of why you are applying for Financial Assistance:

_____

_____

_____

_____

SECTION VI: CERTIFICATION BY APPLICANT

I declare under penalty of perjury that the answers I have given are true and complete to the best of my knowledge.

I understand that I may be asked to prove my statements and that my eligibility statements may be subject to verification by contact with my employer, credit verification, and property ownership searches.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets, while this application is in process and if approved, for the entire period I am receiving financial assistance.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by the Hospital and/or Clinic.

_____ _____

Signature of Applicant Date