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 | $ |
| Savings Account Balance | $ |
| Investments | $ |
| Retirement Accounts | $ |
| Other: _____ | $ |

Total Cash and Investments: $_____

Brown County Hospital does not take into consideration your home or automobiles. Any additional resources, please list below: (i.e. boat, trailer)

| Description of asset: | Value of asset: |
|---|---|
| | $ |
| | $ |

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)<br>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

| 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 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.

Guarantor Account Number:_____

| _____ | _____ |
| --- | --- |
| Signature of Applicant | Date |