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**
    - Rock County (888)794-5780
    - Winnebago County (815)987-7620
  - **Wisconsin Well Woman Program**
    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.

Beloit Health System

FINANCIAL APPLICATION

GENERAL INFORMATION			
APPLICANT LAST NAME	PATIENT FIRST NAME	MI	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY STATE ZIP		DATE OF BIRTH
TELEPHONE – HOME	TELEPHONE – WORK		TELEPHONE - CELL
E-MAIL ADDRESS	SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH

IDENTIFY AND LIST NUMBER OF DEPENDENTS AS SHOWN ON TAX RETURN: _____

FAMILY STATUS: LIST ALL DEPENDENTS THAT YOU SUPPORT		
NAME	AGE	RELATIONSHIP TO APPLICANT

EMPLOYMENT INFORMATION	
APPLICANT	SPOUSE
EMPLOYMENT STATUS: (CHECK BOX) ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER _____ **IF EMPLOYED:** EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____ OCCUPATION: _____ DATE HIRED: _____ GROSS MONTHLY SALARY: $_____ **IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER?** ☐ YES ☐ NO **IF YES, DID YOU RECEIVE THIS INSURANCE?** ☐ YES IF YES, CARRIER _____ ☐ NO Monthly Premium: $_____ **IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY**	**EMPLOYMENT STATUS: (CHECK BOX)** ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER _____ **IF EMPLOYED:** EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____ OCCUPATION: _____ DATE HIRED: _____ GROSS MONTHLY SALARY: $_____ **IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER?** ☐ YES ☐ NO **IF YES, DID YOU RECEIVE THIS INSURANCE?** ☐ YES IF YES, CARRIER _____ ☐ NO Monthly Premium: $_____ **IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY**
IF UNEMPLOYED:	**IF UNEMPLOYED:**

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Beloit Health System

FINANCIAL APPLICATION

DATE UNEMPLOYED _____ REASON FOR UNEMPLOYMENT _____	DATE UNEMPLOYED _____ REASON FOR UNEMPLOYMENT _____

MONTHLY INCOME: PLEASE LIST ALL SOURCES 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? _____

_____

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		$

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Beloit Health System

FINANCIAL APPLICATION

MONTHLY EXPENSES: Rent/Loans		
EXPENSE	**OUTSTANDING BALANCE**	**MONTHLY PAYMENT**
RENT OR MORTGAGE	**$**	**$**
AUTO LOAN(S)	**$**	**$**
OTHER LOANS	**$**	**$**
	$	**$**

OTHER MONTHLY EXPENSES:		
CHILD SUPPORT $	**FOOD $**	**MEDICINE /PHARMACY $**
OTHER COURT ORDERED $	**GASOLINE /TRANSPORTATION $**	**OTHER $**
UTILITIES: GAS/ FUEL /ELECTRIC /SEWER /WATER $	**TELEPHONE/ CELL PHONE $**	**OTHER $**
INSURANCE PREMIUM(S) $	**SCHOOL EXPENSES $**	**OTHER $**

ANY OTHER INFORMATION YOU WOULD LIKE TO PROVIDE FOR CONSIDERATION: Attach additional pages, if necessary

By signing below, you certify on behalf of yourself and your household to Beloit Health System that:

1. The information you have provided on this Application is true, accurate and complete to the best of my knowledge;
2. I understand I may be required to provide proof of the information I am providing;
3. Beloit Health System may obtain a personal credit bureau report to verify outstanding financial obligations; and
4. No member of my household carries any insurance that would pay for any portion of any financial obligation we may have to Beloit Health System; AND/OR, we have provided all relevant insurance information to Beloit Health System.

Authorization for Release of Information: I authorize Beloit Health System to verify all information provided with this application, including communications with third parties on behalf of myself and my family. I may revoke this authorization at any time in writing, except to the extent that Beloit Health System has already acted in reliance upon it. I understand that a photocopy of this authorization has the same effect as the original.

_____ _____

(PATIENT/GUARANTOR SIGNATURE) (DATE)

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