Dear Patient:

Enclosed is a Financial Assistance Form. This form is utilized to assess situations in which Dean Health System patients are experiencing difficulty paying for their medical expenses.

Please complete the form entirely, and return it to us in the envelope provided. Once we have reviewed your information, if it appears you are eligible for any public assistance programs, we will assist you in applying for the program or direct you on how you can apply. If you are not eligible for public assistance, Community Services staff will determine if reasonable payment arrangements can be made or if you qualify for assistance through our Community Care Program.

Our Community Care Program is designed for persons with short-term illness. It is not intended to be an alternative to health insurance coverage or government assistance programs. The program relates to services provided by Dean Health System and does not address the following costs:

- Hospital facility fees
- Surgery and Care Center fees
- Pharmaceutical expenses
- Optical purchases (*glasses, contacts etc.*)
- Durable medical equipment or hearing aids
- Elective procedures

IMPORTANT INSTRUCTIONS: In order to assess your situation, we need the enclosed form completed in its entirety. We must receive copies of the following in order to process your form:

- Payroll stubs from the last two months for *each* employed adult in your household
- Bank statements from the last two months, checking and savings accounts
- Income Tax Return for the most recent tax year filed, including all schedules filed with original return
- Copy of your most recent Social Security check (if you do not receive direct deposit into your bank)
- Signed Authorization to Assist with Medical Assistance applications (if applicable)

Processing of your form will be delayed if you do not include these items.

If you would like to be considered for assistance, please complete and return the enclosed form within 30 days. If you need assistance completing the form or if you have any questions, please contact the appropriate staff person listed below:

Mary Moura	608.294.6463 or 800.279.9966 ext. 6463

Thank you. We look forward to assisting you.

Dean CLINIC
Partners who care

FINANCIAL ASSISTANCE FORM

Name of Responsible Party_____ **Male**_____ **Female**_____

Mailing Address_____
Street

_____
City State Zip Code County

Social Security Number_____ **Age**_____ **Date of Birth**_____

U.S. Citizen? Yes / No **Are you a permanent U.S. Resident?** Yes / No **Date of Entry into U.S.** _____

Home Phone_____ **Work Phone**_____ **Other Phone**_____

***Relationship Status** *(circle one)* Single Domestic Partner Married Widowed Divorced Separated

List all individuals residing at your address *(even if they are not applying for assistance)*

Name	Birthdate	Relationship to Responsible Party	U.S. Citizen?	Permanent. U.S resident?	Date of Entry into the U.S.
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

Do you have any children age 18 or under who are not living in your home? Yes / No

Is anyone in the household pregnant? Yes / No Name of person _____

Clinic/Doctor verifying pregnancy _____ Expected Delivery Date_____

Have you recently applied for, or are you receiving:

Foodshare Program (food stamps)?	Yes / No	Approved / Denied	Receiving $_____/month
W-2 cash payments?	Yes / No	Approved / Denied	Receiving $_____/month
Rental assistance?	Yes / No	Approved / Denied	
Energy assistance?	Yes / No	Approved / Denied	
Medical Assistance?	Yes / No	Approved / Denied	

If Approved, covered family members and effective dates _____

Is anyone in your household a veteran? Yes / No If yes, name_____

Is anyone in your household disabled? Yes / No If yes, name_____

Has this person applied for Social Security Disability Benefits? Yes / No

If **yes**, status of application: Approved / Denied / Pending / Appealed / Other _____

If status is other than Approved, date of application _____

Please complete current employment information for **all adults** in your household. Attach additional pages if necessary.

EMPLOYMENT - INCOME INFORMATION FOR_____
(name)

Employment status (*circle one)* Employed full time Employed part time Self-employed Unemployed Retired
Other_____

If **UNEMPLOYED,** unemployment compensation $_____/week Date unemployed _____
Reason for unemployment (*circle one)* Seasonal Permanent layoff Student Medical disability Other:_____

If **RETIRED**, pension and/or Social Security income $_____/month

If **EMPLOYED**, income before taxes $_____/month

Employer Name_____ Employer Address_____

Employer Phone Number_____ Occupation_____

Length of time with current employer_____

Is health insurance available through your employer? Yes / No If **yes**, do you receive this insurance? Yes / No
If you do not receive this insurance, reason why_____

If you do receive this insurance, what is your premium payment per month?_____

("Premium" is the amount deducted from your paycheck for health insurance)

Additional sources of <u>monthly</u> income

Alimony / Maintenance $_____ Child Support Received $_____
SSI or SSDI (disability) $_____ Veteran's Benefits $_____
Worker's Compensation $_____ Rental Income $_____
Support from family or friends $_____ Other (give amount and source)_____

_____

Examples: Interest, dividends, etc

EMPLOYMENT – INCOME INFORMATION FOR _____
(name)

Employment status (*circle one)* Employed full time Employed part time Self-employed Unemployed Retired
Other_____

If **UNEMPLOYED,** unemployment compensation $_____/week Date unemployed _____
Reason for unemployment (*circle one)* Seasonal Permanent layoff Student Medical disability Other:_____

If **RETIRED**, pension and/or Social Security income $_____/month

If **EMPLOYED**, income before taxes $_____/month

Employer Name_____ Employer Address_____

Employer Phone Number_____ Occupation_____

Length of time with current employer_____

Is health insurance available through your employer? Yes / No If **yes**, do you receive this insurance? Yes / No
If you do not receive this insurance, reason why_____

If you do receive this insurance, what is your premium payment per month?_____
("Premium" is the amount deducted from your paycheck for health insurance)

Additional sources of <u>monthly</u> income

Alimony / Maintenance $_____ Child Support Received $_____
SSI or SSDI (disability) $_____ Veteran's Benefits $_____
Worker's Compensation $_____ Rental Income $_____
Support from family or friends $_____ Other (give amount and source)_____

_____

Examples: Interest, dividends, etc

EMPLOYMENT - INCOME INFORMATION FOR _____
(name)

Employment status (*circle one)* Employed full time Employed part time Self-employed Unemployed Retired
Other_____

If **UNEMPLOYED,** unemployment compensation $_____/week Date unemployed _____
Reason for unemployment (*circle one)* Seasonal Permanent layoff Student Medical disability Other:_____

If **RETIRED**, pension and/or Social Security income $_____/month

If **EMPLOYED**, income before taxes $_____/month

Employer Name_____ Employer Address_____

Employer Phone Number_____ Occupation_____

Length of time with current employer_____

Is health insurance available through your employer? Yes / No If **yes**, do you receive this insurance? Yes / No
If you do not receive this insurance, reason why_____

If you do receive this insurance, what is your premium payment per month?_____
("Premium" is the amount deducted from your paycheck for health insurance)

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Worker's Compensation $_____ Rental Income $_____
Support from family or friends $_____ Other (give amount and source)_____

_____
Examples: Interest, dividends, etc

ASSETS

Savings account balance $_____ Other real estate $_____
Checking account balance $_____ Vehicle make/type/year _____
Cash on hand *(not in a bank)* $_____ Vehicle make/type/year _____
Assessed value of home $_____ Other assets (amount and type)_____

_____
Examples: Recreational vehicles, mutual funds, CD's, stocks, bonds, IRA, Roth IRA, etc.

MONTHLY EXPENSES AND OTHER RELATED INFORMATION

Mortgage/Rent $_____ Mortgage loan balance $_____
Auto Loan(s) $_____ Auto loan balance $_____
Utilities $_____
(gas, electric, water)
Child Care $_____
Child support paid out $_____
Court ordered parent _____

Credit Card and Other Loan Expenses

Type	**Total Debt**	**Monthly minimum Payment**
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

Medical Expenses	**Monthly Payment**	**Total Due**
_____ *(clinic/hospital name)*	$_____	$_____
_____ *(clinic/hospital name)*	$_____	$_____

Prescription costs $_____
How much can you afford to pay monthly on your Dean Health System Balance? $_____
Is any portion of your Dean balance related to a third party liability or worker's compensation claim? Yes / No

Please indicate name of your primary care provider and any other providers to whom you have been referred for evaluation or treatment

Physician	**Clinic name**
_____	_____
_____	_____

The information received on this application is confidential and will be used to review your current situation.

Authorization for Representation

Purpose

I, the undersigned herby authorize Dean Health Systems, Inc. and its Community Service employees to discuss and provide copies of my medical and financial file in their efforts to research financial and medical resources on my behalf.

Authorization for Release of Information

Medical Information

This authorization includes the release to Dean Health Systems, Inc. of all clinic and medical information, electrocardiograms, immunization and allergy records, labs, x-rays and eye reports.

I also give special permission in compliance with Wisconsin Statutes for the release to Dean Health Systems, Inc. of mental health, alcohol, HIV (AIDS), drug abuse and developmental disability information pertaining to my file.

Financial Information

This authorization includes the release to Dean Health Systems, Inc. of any financial statements, business reports, payroll or benefit information from my past or present employers, banks or other financial institutions**, credit bureaus** or government agencies.

Other Related Information

Finally, I authorize the release to Dean Health Systems, Inc. of any other related information, including psychological, social, vocational, rehabilitative, or educational reports, assessments or evaluations.

I authorize the release of the above information for the dates up to and including the date of my signature, and for up to one year from the date of my signature.

I understand written notification is required by me to revoke this authorization. I also understand that a photocopy of this authorization has the same effect as the original.

I hereby certify the above information is correct and complete to the best of my knowledge.

Signature of Responsible Party_____ **Date**_____

Signature of Patient _____ **Date**_____

Optional:

I also authorize _____, who is my _____ to discuss my
(name of individual) *(specify relationship)*
application status with any member of the Community Services Staff.

If signed by person other than patient, state relationship and authority to do so.

Patient is: minor / incompetent / disabled **Your authority**: parent / legal / legal guardian

Authorization for Assistance with Medical Assistance Applications

- I authorize Dean Health System Community Services to assist me in completing an online application for BadgerCare Plus.
- I understand that Dean Health System Community Services will not complete this application without my consent.
- I wish to apply for Medicaid benefits. I understand that Dean Health System Community Services staff will assist me, over the phone, to complete this application. Community Services staff will read me the application sections for my input. Community Services staff will help me electronically sign the application. Upon my request, Community Services staff will submit the application to my local county Human Services office.
- I understand an interpreter will be obtained if needed, in order to accurately complete the online application.

Applicant's Name: _____

Applicant's Date of Birth: _____

Applicant's Signature: _____

Date Signed: _____

If this Release is being signed by a representative or parent on behalf of the patient, complete the following:

Patient's Name: _____

Representative's Name: _____

Relationship to Patient: _____