WESTERN WISCONSIN HEALTH

Dear Applicant:

Attached is an application for Western Wisconsin Health's Community Care Program. Our Community Care Program is available to eligible patients who are unable to pay all or part of their hospital and/or Physician charges based on financial need. In order to consider you for the Community Care Program, all the documents listed on the documentation checklist must be provided. If you cannot provide the requested documentation, please indicate the reason(s).

We encourage you to return the application along with the supporting documentation within 14 days. We will review the information and contact you within 30 days of receipt of the completed application. Incomplete applications will be returned to you along with a letter asking for specific documentation.

If you have any questions regarding the application and/or the requirements, please feel free to contact us directly at 715-684-1563.

Applicant Responsibilities

It is an expectation that the patient/guarantor will cooperate and supply all the necessary information required to make a determination for the Community Care Financial Assistance eligibility.

No single organization can meet the needs of all patients who are unable to pay. Community Care works in collaboration with other financial (both public and private) assistance programs. Patients will be asked to pursue all other assistance options for which they may be eligible for prior to their evaluation for Community Care financial assistance

**Please Note: The Community Care Program is not insurance. The discounts awarded under the Community Care Program are granted for WWHealth services and Providers only. The discounts do not apply to the following: Collection/Legal Accounts; Pharmacy; visiting Specialty Physicians, Radiologist, or non-billed WWHealth services.

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WESTERN WISCONSIN HEALTH

1100 BERGSLIEN ST.
BALDWIN WI 54002
715-684-1111

IF YOU HAVE ANY QUESTIONS ON THE APPLICATION, PLEASE CALL

Community Care Application

Applicant: ______________________ Date of Birth: ______________

Street address: ____

City: ______________ State: ______ Zip: ________ Phone: ______________

Spouse's Name: ______________________ Date of Birth: ______________

Veteran: ☐ No ☐ Yes If yes, have you applied for the Veteran's Grant? ______________

	Applicant	**Spouse**
Employer:		
Employer Address:		
Employer Phone:		
Date of Hire:		
Date of Term:		
Previous Employer/Dates:		
Social Security #:		

Health Insurance Policy: ______________ Policy #: ________ Enrollment Date: ________

Does your Employer have Health Insurance Available? ________

Dependents Name **(claimed on taxes)**	Age	Relationship	Dependents Name	Age	Relationship
1.			3.		
2.			4.		

Are any of the BAMC balances that are outstanding the result of a workman compensation or liability (accident) date? ______

Please list applicable dates of service here: ______________________________

List Current Monthly Income (Indicate Amount and Provide Documentation Supporting Each Reported Amount):

☐ None: Complete ATTESTATION LETTER OF SUPPORT.

☐ Wages ________ ☐ Veterans ________ ☐ Pension ________

☐ Child Support ________ ☐ Alimony ________ ☐ Social Security ________

List amounts and dates you have been receiving the following:

☐ Workers Comp $________ ☐ Unemployment $________ ☐ Other $________

Dates________ Dates: ________ Dates: ________

List Your Asset Amounts:

Savings: ____________________ Checking: ____________________ Property: ____________________

IRA: ____________________ Stocks/Bonds:____________________ Non-stead property: ____________

RELEASE OF FINANCIAL INFORMATION

I authorize Western Wisconsin Health Community Care Program to obtain any financial information held by the Social Security Administration, County Social Services, lending institutions or insurance companies on myself, for the purpose of determining eligibility for Community Care funding. This authorization is valid for 90 days from my dated signature. I can revoke it at any time, except, to the extent that the medical center has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original. I hereby certify that information on this application is correct.

Reason for Application: I understand that the Community Care Program is not an insurance program nor is it an entitlement program. It is not meant to replace benefits that are, or could be, received from government-supported or other payment programs. I further understand that I am expected to exhaust all other payment options as a condition of approval for discount consideration under the Community Care Program. My basis for application at this time is:

____

____

____

Signature of Applicant: ____ Date: ______________

If signed by person other than the patient, complete the following:

Signature of legally authorized person: ________________________________ Date: ______________

Patient is: ( ) minor ( ) incompetent ( ) disabled Legal Authority: ( ) legal guardian ( ) parent of minor

YOUR APPLICATION CANNOT BE PROCESSED UNTIL YOU HAVE:

Completed:

1) Community Care Application.
2) Provide verification of Income.
3) Marketplace Insurance Application. Provide documentation of application status.
   - Apply at this Web Site: https://www.healthcare.gov/ or call 1-800-318-2596.
4) Medical Assistance Application within the last 90 days. If you are denied, please provide copy of the denial.
   - Apply at this Web Site: https://access.wisconsin.gov/ or call 1-888-283-0012 for the Great Rivers Consortia Great Rivers Consortia serves the following counties: Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, **Pierce, Polk, St. Croix**, and Washburn.
   - St. Croix County residents can contact St. Croix County Dept. of Health and Human Services at 715-246-8257
   - For Questions regarding the WI Medical Assistance Program (BadgerCare) visit https://www.dhs.wisconsin.gov/forwardhealth/index.htm or call 1-800-362-3002

Attach:

- Copy of your prior year Federal Income Tax forms.
- If you did not file income tax, provide documentation for the previous 12 months outlining your income. This includes bank statements for checking and savings, W-2's, and/or check stubs.
- If you are a Social Security Recipient, attach copy of your Award Letter.

Important:

1. Until your application is approved, your accounts are at risk for outside collection activity.
2. Incomplete applications will be returned.