WATERTOWN
REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE PROGRAM

As part of our mission, Watertown Regional Medical Center is committed to providing access to quality health care to our community, and to treating all our patients with dignity, compassion and respect.

Our Financial Assistance Program provides services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for part or all of their care. Our Financial Assistance Program provides discounts up to 100 percent of hospital/physician charges to patients who meet financial eligibility guidelines.

When applying for Financial Assistance, your cooperation is needed in providing the information and supporting documentation necessary for us to make a fair and timely decision. If complete and accurate information is not provided, your application may be rejected or denied without further review, in which case you will be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or family members will be handled in strict confidence and in a compassionate manner.

Thank you for selecting Watertown Regional Medical Center for your health care needs. We take pride in serving the health care needs of our community!

Copies of this application form are available in English and Spanish.
Copias de la solicitud de asistencia financiera están disponibles en Inglés y Español.

WATERTOWN
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This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact a Financial Service Representative at (920)262-4396.

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (WI driver's license/WI ID).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, etc.
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ A copy of a current utility bill, telephone bill, or cable television bill from the residence at which you reside.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.
- ✓ If you report $0 income on the following page, a completed Support Statement (at the end of the form) from any person(s) providing support to you or your family.

☞ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided.

Please contact the appropriate Financial Service Representative to schedule an on-site or telephone interview.

Financial Service Representatives (Hospital):

Last name beginning A-L	(920) 262-4396
Last name beginning M-Z	(920) 262-4228

Financial Service Representatives (Clinic):

Last name beginning A-Z	(920)262-4321

The Patient Protection and Affordable Care Act requires all individuals to have health insurance coverage effective as of January 1, 2014. Our Financial Service Representatives will provide you with information as to how you can apply for health insurance coverage through the federal insurance exchange at "www.marketplace.gov" and can help you with the enrollment process.

FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address Since _____ Phone # (_____) _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Social Security # _____ Date of Birth _____

☞ **If credit report indicates high risk, a copy of your social security card(s) will be required.**

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position _____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This Semester _____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

Employment information of Spouse (if applicable):

Spouse's Employer _____ Unemployed ? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This semester _____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

IV. MONTHLY EXPENSE INFORMATION

Indicate monthly amounts paid or owed on items below:

RENT / MORTGAGE		**HOUSEHOLD BILLS**	
Landlord Name		Heat / Utilities	$
Landlord Phone #	( )	Phone / Cell Phone	$
Mortgage Lender		Cable TV / Internet	$
Mortgage Amount	$	Homeowner's Insurance	$
		Auto Insurance	$
LOANS		Health, Dental, Vision Insurance	$
Auto Loans	$	Life or Disability Insurance	$
Personal Loans	$	Other Insurance	$
Student Loans	$	Medical Bills (hospital / clinic)	$
OTHER OBLIGATIONS		**CREDIT CARDS**	
Child Care	$	Credit Card	$
Child Support	$	Credit Card	$
Alimony	$	Credit Card	$
Other	$		

TOTAL MONTHLY EXPENSES: $_____

V. ASSETS

Indicate current fair market value of any of the following:

BANK ACCOUNTS		**REAL ESTATE OWNED**	
Name of Bank		Value	$
Savings	$	Street Address	
Checking	$	City, State and ZIP	

VEHICLES OWNED				**LIST OTHER ASSETS**	
	Year/Make	Model	Value		$
First			$		$
Second			$		$
Third			$		$

TOTAL ASSETS: $_____

VI. SUPPORT STATEMENT

If you report monthly income of $0 in Part III above, please have the attached Support Statement filled out by the person(s) helping you and/or your family. In all other cases, skip this section.

VII. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Watertown Regional Medical Center, and I authorize Watertown Regional Medical Center to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request_____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering the materials to:
  - A Financial Service Representative
  - The Patient Accounting Office at Watertown Regional Medical Center, 125 Hospital Dr., Watertown, WI 53098 (Hospital lobby, next to Patient Registration Desk)
  - The Patient Registration Desk at any WRMC Clinic
- Mailing the materials to Watertown Regional Medical Center, Attn: Patient Accounting Office, 125 Hospital Dr., Watertown, WI 53098
- E-mailing the materials to WMH_Billing@WatertownRegional.com

***** To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application *****

Applicants will be notified within 60 days after submission of a complete application with all required supporting documentation

Support Statement

(To be completed by the person providing support to the applicant)

Print Full Name: _____ Phone # (_____)_____

Address: _____
Street City State Zip Code

Social Security Number: _____ Date of Birth _____

I have been identified by the applicant as providing financial support. Below is a list of services or support I provide the applicant.

_____

_____

_____

_____

_____

_____

I hereby certify and verify that all of the above information is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

Signature _____

*** Please attach proof of residency, such as a copy of a utility bill, with your current address on it, dated within 60 days from the date of the hospital service.