Hospital and Clinics
235 State Street, St. Croix Falls, WI 54024
715-483-3261
www.scrmc.org

Dear Patient,

We are pleased you have requested materials for our Financial Assistance Program.

Approval for our Financial Assistance Program will be determined based upon income guidelines and family size and eligibility for state and federal health coverage.

If you wish to apply, please complete and return the attached application along with required paperwork within 30 days. If you need assistance completing this application, please call a Patient Financial Counselor at (715) 483-0475 or 1-800-828-3627 x 2475 Monday through Friday 8 am to 4:30 pm.

The Financial Assistance Program applies to specific services provided by our medical center and clinics only. Not all services are eligible. The program is designed to assist with financial burden on a short-term basis and it is not designed to be an alternative to health insurance.

Thank you for choosing St. Croix Regional Medical Center for your health care needs. We look forward to assisting you.

Sincerely,

Dave Dobosenski
Chief Executive Officer

CLINICS Toll Free 800-828-3627

St. Croix Falls Clinic	Frederic Clinic	Unity Clinic	Ingalls Clinic	Lindstrom Clinic
216 South Adams Street	107 Oak Street East	1504 190th Avenue	7456 Main Street West	12375 Lindstrom Lane
St. Croix Falls, WI 54024	Frederic, WI 54837	Balsam Lake, WI 54810	Webster, WI 54889	Lindstrom, MN 55045
715-483-3221	715-327-5700	715-825-3278	715-866-4271	651-400-2240

PLAIN LANGUAGE SUMMARY

St. Croix Regional Medical Center's Financial Assistance Policy assists with emergent, inpatient and outpatient medically necessary expenses and is available for those who meet eligibility criteria.

WHO CAN APPLY

All patients/guarantors can apply for financial assistance. This Policy provides discounted care for medically necessary healthcare for those who have:

- Submitted a complete financial assistance application.
- Income within the guidelines. See table below.
- Exhausted all other payment options and insurability.

Patient Financial Counselors will assist patients, who do not have insurance, in applying for Medicaid (MN and WI), MNSure, or Federal Insurance Exchange (Marketplace).

Persons in Family/ Household	250% Poverty Guideline (annual income)
1	$31,225
2	$42,275
3	$53,325
4	$64,375
5	$75,425
6	$86,475
7	$97,525
8	$108,575
For Family/Households with more than 8 persons, add $11,050 for each additional person.	

HOW TO APPLY

Ask or call a **Patient Financial Counselor at 715-483-0475 or toll free at 1-800-828-3627 ext 2475** Monday –Friday 8 am to 4:30 pm

Go to http:// www.scrmc.org

You can apply at St. Croix Regional Medical Center or Clinics:

- St. Croix Regional Medical Center
  235 State Street
  St. Croix Falls, WI 54024
- Frederic Clinic
  205 Oak Street West
  Frederic, WI 54837
- Webster Clinic
  26425 Lakeland Ave So
  Webster, WI 54893
- Lindstrom Clinic
  12375 Lindstrom Lane
  Lindstrom, MN 55045
- Unity Clinic
  1504 190th Street
  Balsam Lake, WI 54810

FOR FREE COPIES OF THE POLICY AND APPLICATION AND/OR HELP

- A free copy of the policy and application is available at the Emergency Department, Registration staff at all facilities, Patient Financial Counselors or at our website www.scrmc.org

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS & REQUIREMENTS

- Completed and signed application.
- Most recent copy of Federal Tax Return.
- Paperwork confirming that the patient has applied for Medical Assistance within three (3) months of application date for financial assistance including decision (WI & MN residents only)

  Wisconsin Residents: To apply online, go to ACCESS.wi.gov and click on Apply for Benefits. ACCESS is also the fastest and easiest way to apply for all forms of Badger Care Plus.
  By Phone: 1-888-283-0012 Great Rivers Consortium

  Minnesota Residents: To apply online, go to MNSURE.org and click on Medical Assistance or MinnesotaCare By Phone: 855-366-7873

  Minnesota Residents receiving social security benefits: contact your local county human services office and apply for MN Medicaid.

- Income Verification, examples include:
  - Pay check stubs with year-to-date earnings (3 most recent) and/or;
  - Bank Statements to support income and/or;
  - Annual statement of Social Security benefits and;
  - Statement of income from any private or government agency that provides you with benefits (if applicable)
  - Proof of year-to-date child support or alimony payments (if applicable)
  - Documentation that patient has applied for disability coverage and has received a coverage determination (if applicable)
  - Provide the marketplace exemption Electronic Confirmation Number if the patient qualifies for Affordable Care Act exemption.

<u>Application Deadline</u>: Applicants will be given 30 days to complete the Financial Assistance Application and provide requested documentation

<u>Submit application by:</u>

HAND DELIVER: To any of our Patient Financial Counselors at any of our facilities.

MAIL TO: SCRMC Attn: Patient Financial Counselors
235 State Street
St. Croix Falls, WI 54024

FAX TO: 715-483-0505 Attn: Patient Financial Counselors

QUESTIONS: Patient Financial Counselors can be reached 715-483-0475

St Croix Regional Medical Center reserves the right to request additional information to determine eligibility

April, 2019

FINANCIAL ASSISTANCE APPLICATION

1. Applicant			
Name:	Date of Birth:		Phone:
Address:			
City:	State:	Zip:	
Social Security #:			
Spouse's Name:	Date of Birth:		Phone:

2. Dependents		
Name:	Date of Birth:	Relationship:
Name:		
Name:		
Name:		

3. Monthly Income	Applicant	Spouse
Wages	$	$
Self-employment	$	$
Public assistance	$	$
Child Support/alimony	$	$
Pension/dividends	$	$
Unemployment	$	$
Social Security and Disability	$	$
Veterans' payments	$	$
Tribal Income	$	$
Tips/Commission	$	$
Income from estates/ trusts	$	$
Educational assistance	$	$
Other income	$	$

4. Health Insurance Coverage		
Name/Household member	Insurance	Policy #

FINANCIAL ASSISTANCE APPLICATION

5. Applicant's Employment:_______________________________________
Hourly wage?______Hours per week_________

Employment:_______________________________________
Hourly wage?______Hours per week_________

6. Spouse's Employment:_______________________________________
Hourly wage?______Hours per week_________

Employment:_______________________________________
Hourly wage?______Hours per week_________

7. If you did not file a recent tax return, please explain:_________________________

____

8. In relation to your medical bills, do you have a lawsuit or insurance claim because of an accident or injury? _______(Yes or No) or Spouse _______(Yes or No)
Name/phone of your attorney_______________________________________

9. In relation to your medical bills, do you have workers compensation case?
___(Yes or No) or Spouse _______(Yes or No)
Insurance carrier/attorney_______________________________________
Insurance carrier/attorney_______________________________________

10. In relation to your medical bills, do you have motor vehicle case?
___(Yes or No) or Spouse _______(Yes or No)
Insurance carrier/attorney_______________________________________
Insurance carrier/attorney_______________________________________

11. In relation to your medical bills, do you have third-party liability case?
___(Yes or No) or Spouse _______(Yes or No)
Insurance carrier/attorney_______________________________________
Insurance carrier/attorney_______________________________________

I certify that the above information is true and correct. I will notify St. Croix Regional Medical Center's Patient Financial Counselors at 715-483-0475 or toll free at 1-800-828-3627 ext. 2475 of any changes in the information provided on this form. I also understand that my application is subject to the guidelines of St. Croix Regional Medical Center's Financial Assistance Policy.

I understand that the information submitted concerning my annual income and family size is subject to verification by St. Croix Regional Medical Center. I also understand that if the information submitted is determined to be false, this will result in a denial of this application and the account balance due will remain my responsibility.

I hereby authorize St. Croix Regional Medical Center to review federal and state records of employment and income history,

Signature:_______________________________________Date:_____________________