ST. CROIX REGIONAL MEDICAL CENTER

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.

The approval for our financial assistance program is determined based on income guidelines, family size and eligibility for state and federal health coverage.

As stated in our Financial Assistance policy, the program assists individuals with service dates that go back 240 days from the date a **"completed"** application is submitted and go forward for 12 months, so long as there are no changes to income and/or insurance coverage and/or family size.

If you wish to apply, please return the attached application, along with all necessary documentation within 30 days. Your submission is marked as complete on the date we receive the required paperwork in the attached instruction sheet, plus your application. 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.

Our Financial Assistance Program is designed exclusively for the Hospital and Clinics of St Croix Regional Medical Center. Not all services provided by our medical centers are eligible as stated in our financial assistance policy. The program is intended to ease financial burden on a short-term basis and is not created as an alternative to health insurance.

Thank you for choosing St. Croix Regional Medical Center. It is our privilege to help you manage your health care.

Sincerely,

Dave Dobosenski
Chief Executive Officer

Our *Financial Assistance* policy is available at www.scrmc.org or you may request a copy at any SCRMC facility at the registration desk, emergency department or by calling a financial counselor at 715-483-0475.

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS & REQUIREMENTS

- Completed and signed application.
- Most recent Federal Tax Return copy including self-employment pages ***(Applicant for Financial Assistance must be the individual who claims you as a dependent on their federal tax return).***
- All pages of the approval or denial letter confirming the applicant applied for and completed a request for Medical Assistance within the last (3) months. (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 for all household members-Examples include:
  - Pay check stubs with year-to-date earnings (3 most recent)
  - Annual statement of Social Security benefits
  - Statement of income from retirement and/or pension benefits (if applicable)
  - Unemployment benefits and/or short or long term disability (if applicable)
  - Bank Statements to support income (if applicable)
  - Proof of year-to-date child support or alimony payments (if applicable)

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

Submit application by:

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

ST. CROIX REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

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

2. Dependants		
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:_____