

APPLICATION FOR FINANCIAL ASSISTANCE

Beloit Memorial Hospital provides services free or at a reduced charge to eligible persons who cannot afford to pay for care.

In order to apply for this program, please complete the following forms. Return these completed forms along with proof of household monthly income for the last three (3) months and the last twelve (12) months. Examples of income proof would be: pay stubs, check vouchers or a letter from your employer indicating net monthly income, AFDC income statements, unemployment statements, Social Security benefits or Workers Compensation benefits. In other words, ***you need to provide anything that will verify what you have indicated on these forms.***

After you have obtained the required information, please submit your application to one of our Credit Consultants by mail or in person. If you have any questions, please contact our Credit Consultants as listed below:

	First Letter of Last Name	
Ami Menke	A – K	(608)364-5584
Jenny Gonfiantini	L – Z	(608)364-5585

If you are calling long distance, you may use our toll-free number and ask to speak with a Credit Consultant: 1-800-846-1150.

Beloit Memorial Hospital will send a written determination of your request within seven (7) working days of receiving your completed application.

Thank you,

Deborah JB Gustafson
Manager Patient Accounts

FINANCIAL ASSISTANCE APPLICATION CHECK LIST

Date _____

Applicant: _____

Accounts: _____

Please provide the following information in order to be considered for the Beloit Memorial Hospital Financial Assistance Program:

Proof of **Household Net Monthly Income** for the *LAST 3 MONTHS AND THE LAST 12 MONTHS*, by way of:

- ____ Wage check stubs, tax returns, statement from employer
- ____ Disability, sick pay, or Social Security income
- ____ Unemployment, settlement or pension income
- ____ AFDC, IPA, or Public Aid income, child support
- ____ Food Stamps or Heat Assistance benefits
- ____ Student loans and/or grant income
- ____ Rental, self-employment, or third party support (complete enclosed form)
- ____ Other: _____

Social Services Rejection: Rock County (608)741-3488

Winnebago County (815)987-7620

- ____ When do WMA, IPA, or Public Aid benefits begin? Which family members are eligible?
- ____ WMA, IPA, or Public Aid rejection (including Health Start, Spend Down, and Medically Needy programs)
- ____ Other: _____

Statement from Employer:

- ____ Start date of health insurance. Which family members are eligible?
- ____ No health insurance benefits available.
- ____ Claims are not eligible for workers compensation/liability benefits.
- ____ Other: _____

Please contact our Credit Consultants if you have any questions.

Beloit Memorial Hospital, Inc
Request for Determination of Eligibility for Financial Assistance

I hereby request that Beloit Memorial Hospital make a written determination of my eligibility for financial assistance. I understand that the information I submit concerning my annual income and family size is subject to verification by Beloit Memorial Hospital. I also understand that if the information I submit is determined to be false, I will be denied financial assistance and I will be liable for all charges for services rendered.

NAME _____
First Middle Last
 ADDRESS _____
Number and Street City State Zip
 TELEPHONE NUMBER _____
 OCCUPATION _____
 EMPLOYER _____

INCOME: List income for all individuals living within your household, and attach proof of income.
Total for Last 3 Months Total for Last 12 Months

Net Wages	_____	_____
Self-Employment or Personal	_____	_____
AFDC Benefits	_____	_____
Food Stamps/Heat Assistance	_____	_____
Social Security/Disability	_____	_____
Unemployment Compensation	_____	_____
Workers Compensation	_____	_____
Child Support	_____	_____
Pensions	_____	_____
Income from Dividends, Interest, or Rental	_____	_____
TOTAL INCOME	_____	_____

FAMILY SIZE _____ (All persons living in the same household.)

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I affirm that the information given is true and correct to the best of my knowledge.

_____ Date

_____ Signature of Person Making Request

**BELOIT MEMORIAL HOSPITAL, INC
1969 W. HART ROAD
BELOIT, 53511**

FINANCIAL QUESTIONNAIRE

NAME _____

ADDRESS _____

PHONE _____ SPOUSE _____

ACCOUNTS: _____

INCOME

CURRENT EMPLOYER & ADDRESS _____

POSITION / TITLE _____ LENGTH OF EMPLOYMENT _____

HOURLY WAGE _____ MONTHLY TAKE-HOME PAY _____

SPOUSE'S EMPLOYER & ADDRESS _____

POSITION / TITLE _____ LENGTH OF EMPLOYMENT _____

HOURLY WAGE _____ MONTHLY TAKE-HOME PAY _____

OTHER SOURCE OF INCOME _____

MONTHLY TAKE-HOME PAY _____

ASSETS

SAVINGS ACCT: BANK / CREDIT UNION NAME _____
BALANCES _____

CHECKING ACCT: BANK / CREDIT UNION NAME _____
BALANCES _____

BONDS / CD'S _____ OTHER _____

EXPENSES

	NAME	MO. PYMT	AMT DUE
HOME/RENTING __ BUYING __	_____	_____	_____
UTILITIES	_____	_____	_____
GAS, FUEL, OIL	_____	_____	_____
SEWER	_____	_____	_____
GROCERIES	_____	_____	_____

TELEPHONE	_____	_____	_____
TRANSPORTATION	_____	_____	_____
SCHOOL EXPENSES	_____	_____	_____
CHILD CARE	_____	_____	_____
VEHICLE LOAN	_____	_____	_____
VEHICLE LOAN #2	_____	_____	_____
VEHICLE INSURANCE	_____	_____	_____
FURNITURE	_____	_____	_____
LIFE INSURANCE	_____	_____	_____
HEALTH INSURANCE	_____	_____	_____
HOME INSURANCE	_____	_____	_____
MEDICINE / PHARMACY	_____	_____	_____
DOCTORS / CLINICS	_____	_____	_____
	_____	_____	_____
HOSPITALS	_____	_____	_____
	_____	_____	_____
CHARGE ACCOUNTS	_____	_____	_____
	_____	_____	_____
CABLE	_____	_____	_____
MISC LOANS	_____	_____	_____
TOTAL		\$ _____	\$ _____

This information will be held in strictest confidence by Beloit Memorial Hospital and its employees and may be used to determine eligibility for extended credit terms.

I hereby authorize Beloit Memorial Hospital to verify the information provided above with any individual, organization, or corporation necessary.

Signature of Responsible Party _____ Date _____