Edgerton HOSPITAL AND HEALTH SERVICES
11101 N. SHERMAN ROAD
EDGERTON, WI 53534

READ CAREFULLY!

Application Instructions

In order for your Community Application to receive proper consideration, each of the following requirements must be met:

❒ Complete and sign the application attached to this form, **Incomplete applications will be returned to you for further information**.

❒ Along with the application, you must include AT LEAST three forms of proof of household income. There must be proof of income for each person living in the household (with the exception of children), **regardless of relation to the patient or guarantor**. Some examples of proof of income are:

- Most recent income tax return
- Current W-2 forms
- Most recent paycheck stubs (must be for ONE FULL MONTH'S income)
- Current bank statements
- Copy of Social Security Benefits statement
- Copy of Government-assistance benefits statement

❒ The PATIENT must obtain a written denial from the County Medical Assistance Board (a.k.a. BadgerCare), from the county in which the patient resides, and include a copy of the denial with your application. The easiest, fastest way to apply for BadgerCare is to apply online by visiting this website:

www.access.wi.gov

For your convenience, below are the telephone numbers for these local counties:

- ROCK COUNTY (608)741-3400
  The application can be completed over the phone. If you do not qualify, they will mail a written denial letter to you.
- DANE COUNTY (608)242-7441
  Leave a message stating that you need a BadgerCare application, along with your full name, SSN, and address. It can take up to 30 days to receive a response to your application.
- JEFFERSON COUNTY (920)674-7500
  You must set up an appointment with the Jefferson County office to be seen for eligibility verification. Be sure to ask for a written application.

Once we receive your completed application and all of the required documentation, we will review the application, and send you a written determination of your eligibility for Community Care. This determination will tell you if you qualify, and if so, the percentage of reduction we will allow. **Community Care reductions are valid for eligible services performed up to eight months prior to your application date**. For expenses more than eight months old, you must set up an agreeable payment arrangement for the balance due.

If you have any questions or concerns about applying for Community Care, do not hesitate to call me at **(608)884-1666**. I will be happy to assist you. Thank you!

Self Pay Coordinator Phone: (608)884-1666 Fax: (608)884-1669

Edgerton Hospital and Health Services
Financial Information Statement

Patient Name:_____ Medical Record #_____

Guarantor Name_____ Relationship to Patient:_____

Marital Status (check one): ❑Married ❑Single ❑Separated ❑Divorced ❑Widowed

Patient / Guarantor	**Spouse / Other Household Member**
	Name:_____
Social Security Number:_____	Social Security Number:_____
Address:_____	Address:_____
_____	_____
County:_____ Home Phone:_____	County:_____ Home Phone:_____
If unemployed, last date worked:_____	If unemployed, last date worked:_____
Most Recent Employer:_____	Most Recent Employer:_____
Employment Dates:_____	Employment Dates:_____
Employer Address:_____	Employer Address:_____
_____	_____
Employer Phone:_____	Employer Phone:_____
Job Title:_____	Job Title:_____
❑Full Time ❑Part Time Hourly Wage:_____	❑Full Time ❑Part Time Hourly Wage:_____
Monthly Income	**Monthly Income**
Gross Monthly Income:_____ Net_____	Gross Monthly Income:_____ Net_____
Social Security Income: $_____	Social Security Income: $_____
Pension $_____	Pension $_____
Rental Property Income: $_____	Rental Property Income: $_____
Unemployment Compensation: $_____	Unemployment Compensation: $_____
Dividends/Interest: $_____	Dividends/Interest: $_____
Child Support or Alimony: $_____	Child Support or Alimony: $_____
Other:_____ $_____	Other:_____ $_____
Other:_____ $_____	Other:_____ $_____
Total Income: **$**_____	**Total Income:** **$**_____

Total Combined Monthly Income: $_____

Continued on next page.

Monthly Expenses

Guarantor Monthly Expenses		**Spouse/Other Household Member Monthly Expenses (if applicable)**	
Mortgage Payment:	$_____	Mortgage Payment:	$_____
Rent Payment:	$_____	Rent Payment:	$_____
Real Estate Taxes:	$_____	Real Estate Taxes:	$_____
Utilities (Electricity, Gas, Water):	$_____	Utilities (Electricity, Gas, Water):	$_____
Car / Truck Payment:	$_____	Car / Truck Payment:	$_____
Auto / Home Insurance:	$_____	Auto / Home Insurance:	$_____
Cable TV / Satelite:	$_____	Cable TV:	$_____
Telephone:	$_____	Telephone:	$_____
Cell Phone / Pager:	$_____	Cell Phone / Pager:	$_____
Medication:	$_____	Medication:	$_____
Child Care:	$_____	Child Care:	$_____
Food / Groceries:	$_____	Food / Groceries:	$_____
Auto / Home Maintainance:	$_____	Auto / Home Maintainance:	$_____
Other:_____	$_____	Other:_____	$_____
Other:_____	$_____	Other:_____	$_____
Other:_____	$_____	Other:_____	$_____
Total Expenses:	**$**_____	**Total Expenses:**	**$**_____

Household / Family Bills:

Hospitals and/or Clinics (List Hospital/Clinic names):	Balance:	Monthly Payment
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

Bank / Credit Union Loans (List purpose of loan):		
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

Credit Cards or Lines of Credit (List reasons for use):		
1. _____	$_____	$_____
2. _____	$_____	$_____
3. _____	$_____	$_____

If you have additional expenses, please attach a separate sheet.

Total Monthly Expenses: $_____

Continued on next page.

Assets:	Own	Lease	Balanced Owed	Name of Financing Institution
Automobiles (year/make/model)				
Snowmobiles/Off Road Vehicles				
Motorcycle (year/make/model)				
Boats/Recreational Vehicles				
Real Estate				
	Value			
Retirement Account (401K or IRA)				

Other Information:
If you are listing yourself as "UNEMPLOYED," you must provide a description of the reasons for your unemployment, including factors that are preventing you from working:_____

_____

_____

Number of household members (including yourself and all adults & children):_____

Any other remarks for comments that you feel may be useful in determining your eligibility:_____

_____

_____

Authorization:
The information stated in this application is complete and correct to the best of my knowledge. I authorize Edgerton Hospital and Health Services to verify this information, if necessary, and to obtain information from credit reporting agencies. I understand this application and all information herein will remain confidential and will be used only for the purposes of determining my financial responsibility for my charges at Edgerton Hospital and Health Services.

Signature:_____

Spouse/Other Household Member Signature:_____

Date Signed:_____

☐Check here if this form was completed via telephone.
If checked, name of person whom obtained information:_____

IMPORTANT NOTE TO APPLICANTS:
You must include the following items in order for your application to be considered:

- ❑ 3 forms of household income (previous years tax returns, pay stubs, bank statements, etc.).
- ❑ County Medical Assistance (Medicaid) Denial for each patient who has received services through Edgerton Hospital and Health Services.
- ❑ If receiving Social Security Benefits, VA benefits, or any other government aide, copies of these statements showing amount of benefits must be included.
- ❑ If listing yourself as unemployed, you must include a statement of reasons, including what is preventing you from presently working.

FOR OFFICE USE ONLY

Date Application Received_____Received by_____

All documentation attached? ❑Yes (If not, do not forward for review until all items are received.)

- ❑ 3 forms of household income (previous year's tax returns, pay stubs, bank statements, etc.).
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- ❑ If receiving Social Security Benefits, VA benefits, or any other government aide, copies of these statements showing amount of benefits must be included.
- ❑ If listing yourself as unemployed, you must include a statement of reasons, including what is preventing you from presently working.

Credit Report? ❑Yes ❑No

ACTIONS TAKEN:	Date / Initials

Percentage to be written off		100%	80%	60%	40%	20%
# in Household	Yearly Income	175%	200%	225%	250%	275%
1	$12,060.00	$21,105.00	$24,120.00	$27,135.00	$30,150.00	$33,165.00
2	$16,240.00	$28,420.00	$32,480.00	$36,540.00	$40,600.00	$44,660.00
3	$20,240.00	$35,420.00	$40,480.00	$45,945.00	$51,050.00	$56,155.00
4	$24,600.00	$43,050.00	$49,200.00	$55,350.00	$61,500.00	$67,650.00
5	$28,780.00	$50,365.00	$57,560.00	$64,755.00	$71,950.00	$79,145.00
6	$32,960.00	$57,680.00	$65,920.00	$74,160.00	$82,400.00	$90,640.00
7	$37,140.00	$64,995.00	$74,280.00	$83,565.00	$92,850.00	$102,135.00
8	$41,320.00	$72,310.00	$82,640.00	$92,970.00	103,300.00	$113,630.00
9	$45,500.00	$79,625.00	$91,000.00	$102,375.00	$113,750.00	$125,125.00
10	$49,680.00	$86,940.00	$99,360.00	$111,780.00	$124,200.00	$136,620.00

Included Accounts

Account Number	Date of Service	Dollar Amount	Write off GL

Total Amount Approved for Community Care

Date of Final Determination:_____ Authorized by:_____

Date Applicant Notified:_____Notified by:_____

NOTES: