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.)

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- ❑ 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	**$12,880.00**	**$22,540.00**	**$25,760.00**	**$28,980.00**	**$32,200.00**	**$35,420.00**
2	**$17,420.00**	**$30,485.00**	**$34,840.00**	**$39,195.00**	**$43,550.00**	**$47,905.00**
3	**$21,960.00**	**$38,430.00**	**$43,920.00**	**$49,410.00**	**$54,900.00**	**$60,390.00**
4	**$26,500.00**	**$46,375.00**	**$53,000.00**	**$59,625.00**	**$66,250.00**	**$72,875.00**
5	**$31,040.00**	**$54,320.00**	**$62,080.00**	**$69,840.00**	**$77,600.00**	**$85,360.00**
6	**$35,580.00**	**$62,265.00**	**$71,160.00**	**$80,055.00**	**$88,950.00**	**$97,845.00**
7	**$40,120.00**	**$70,210.00**	**$80,240.00**	**$90,270.00**	**$100,300.00**	**$110,330.00**
8	**$44,660.00**	**$78,155.00**	**$89,320.00**	**$100,485.00**	**$111,650.00**	**$122,815.00**
9	**$49,200.00**	**$86,100.00**	**$98,400.00**	**$110,700.00**	**$123,000.00**	**$135,300.00**
10	**$53,740.00**	**$94,045.00**	**$107,480.00**	**$120,915.00**	**$134,350.00**	**$147,785.00**

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: