FINANCIAL ASSISTANCE APPLICATION

Patient Name ___________________ Account Number___________________

Responsible Party Name________________________ Social Security Number______________

Social Security Number______________

Dependents in the household
(This includes spouse, Children under 18 and all other claimed on your tax return.)

Name Age Name Age
_______________________________________ _______________________________________

_______________________________________ _______________________________________

Employment (Anyone in the house providing income)
Employer Name________________________ Hourly Rate_______Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly (Before Taxes)___________________________________
If unemployed, date last worked___________________

OTHER INCOME

	Patient	Spouse/Responsible Party
Social Security		
Pension		
Unemployment		
VA Benefits		
Rental Income		
Stocks, Bonds, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other state/county Assistance? Date Applied_______________
Case number______________

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may request to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help this hospital bill prior to completing this application.

Signature_________________________________Date________________

Crossing Rivers Health Financial Assistance Requirements

Here at Crossing Rivers we may be able to help lessen the financial burden. We are providing this application, because you may qualify for the Community Free Care we offer.

To be eligible for the program, you must have applied for MEDICAID, State or Local Assistance if you don't have active health insurance.

Required Information:

Current Federal Tax return:
If you need a copy of your Federal Tax return please call IRS # 1-800-829-1040.
State Income Tax Return
Employer Pay Stubs
Written Documentation from income sources
Copies of all bank statements for the past three months
401K or Pension information

MEDICARE PATIENTS: If you did not file a tax return:
Supporting W-2
Supporting 1099's
Most recent bank and broker statements
Qualified Medicare benefits

Also please attach a letter and explain your financial situation. If you have no income or your expenses exceed your income, please explain how you are supporting yourself.

If you need help applying for Medical Assistance please contact Bobbi at 608-375-2469. Also you can apply over the phone or on the internet. https://access.wisconsin.gov

Wisconsin 1-855-794-5780 Minnesota 1-800-657-3739 Iowa 1-855-889-7985

If you need assistance regarding Social Security Disability please contact the Social Security office directly at 800-772-1213 or call the Aging and Disability Resource Center in your area. You can also apply online at www.socialsecurity.gov.

If you don't have insurance and don't qualify for Medicaid, you need to apply for Insurance through the market place at 800-318-2596 or online. www.healthcare.gov

To be considered the application and requested information must be signed and returned within 20 days of receiving this application.

Please return completed form to: Crossing Rivers Health Financial Assistance Program 37868 US Hwy 18 Prairie du Chien, WI 53821.