Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE

Completing this application will help Door County Medical Center determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please submit this application to the Patient Financial Services office.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. HOWEVER, a Social Security

Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help us determine whether you qualify for any public programs.

Please complete this form and submit it to the Patient Financial Service office in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

CERTIFICATION STATEMENT

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this DCMC bill. I understand that the information provided in this application may be verified to ensure accuracy. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, and financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient or Applicant Signature:____

Date: ____

FINANCIAL ASSISTANCE PROGRAM

Please provide copies of the following items that are applicable:

- ☐ Current year W-2 withholding statements
- ☐ Most recent complete federal/state income tax forms including schedules
- ☐ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).
- ☐ Forms approving or denying Unemployment, Workers Compensation or Assistance from the Department of Public Aid
- ☐ Statement of annual benefits from Social Security
- ☐ Complete Checking/Savings account statements (past 3 months)
- ☐ Health Savings Account Statement (past 3 months)
- ☐ Other: letter explaining your situation

Your cooperation with Door County Medical Center (DCMC) is extremely important in determining your eligibility for financial assistance. Failure to provide this information will be cause to deny financial assistance.

Please return completed application along with required documentation within 30 days of receipt to the following address:

Patient Financial Services
Attention: Financial Assistance Program
323 South 18th Avenue
Sturgeon Bay, WI 54235

Telephone Toll Free: 1 (920) 746-3502

Fax: (920) 746-3732

Email: DCMC_PFS@dcmedical.org

FINANCIAL ASSISTANCE APPLICATION

APPLICANT/RESPONSIBLE PARTY INFORMATION

APPLICANT NAME: (last, first, middle initial)

BIRTHDATE: SOCIAL SECURITY NUMBER: PHONE NUMBER:

(Optional) RACE: (Optional) ETHNICITY: (Optional) SEX: (Optional) PREFERRED LANGUAGE:

HOME ADDRESS (City, State, Zip):

PREVIOUS ADDRESS (City, State, Zip):

Members of family unit	HOUSEHOLD MEMBER NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT *If Applicant, Self*	Live at home		SOCIAL SECURITY NUMBER	Current Patient?	
				Yes	No		Yes	No
1.								
2.								
3.								
4.								
5.								

PRESUMPTIVE ELIGIBLITY CRITERIA:

Does any of the information below apply to you? If YES, check all that apply. Please provide documentation/verification if you check YES to any of the statements below:

- ❑ Homelessness - shelter
- ❑ Deceased with no estate
- ❑ Mental incapacitation with no one to act on patient's behalf
- ❑ Medicaid eligibility, but not on date of services or for non-covered service
- ❑ Incarceration in penal institution
- ❑ Enrolled in Temporary Assistance for Needy Families (TANF)
- ❑ Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
- ❑ Enrolled in Wisconsin Department of Health Services Housing Assistance Program

Enrollment in the following assistance for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:

- ❑ Woman, Infants and Children Nutrition Program (WIC)
- ❑ Supplemental Nutrition Assistance Program (SNAP)
- ❑ Low Income Home Energy Assistance Program (LIHEAP)
- ❑ Wisconsin Home Energy Assistance Program (WHEAP)
- ❑ Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
- ❑ Receipt of grant assistance for medical services

If you checked YES to any of the above, please stop and send this application and supporting documentation to the appropriate address as shown on page 2.

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veteran's benefits, Medicaid and/or Medicare? If yes, please provide the following information:

Policy holder: ____________________

Insurer:____________________Policy number: ____________________

Were you covered or eligible under a spouse/partner or former spouse/partner's health insurance policy, foreign coverage policy, Health Insurance Marketplace policy, Veteran's benefits, Medicaid and/or Medicare policy for any or all of your medical services?

Former spouse/partner name:____________________Phone number:____________________

Former spouse/partner address: ____________________

EMPLOYMENT 1: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):	
SALARY (GROSS): ___________(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ TWICE A MONTH ❑ MONTHLY ❑ ANNUALLY	HOW LONG: YR__________MO	POSITION:

EMPLOYMENT 2: HOUSEHOLD MEMBER	EMPLOYER'S NAME:	EMPLOYER'S ADDRESS (City, State, Zip):	
SALARY (GROSS): ___________(AMOUNT)	PERIOD: ❑ WEEKLY ❑ BI-WEEKLY ❑ TWICE A MONTH ❑ MONTHLY ❑ ANNUALLY	HOW LONG: ______YR__________MO	POSITION:

UNEARNED INCOME
Child support does not need be revealed if you do not wish to have it considered as a basis for repaying this obligation.

☐ Please check box if you do not currently file taxes.

TYPE OF UNEARNED INCOME	HOUSEHOLD MEMBER	AMOUNT	PERIOD
1.			
2.			
3.			
4.			
5.			

CHILD SUPPORT: NAME OF CHILD (RECEIVING)	NAME OF PERSON / PARENT PAYING	AMOUNT	PERIOD
1.			
2.			

HOME:	NAME AND ADDRESS OF LANDLORD	RENT PMT:	DUE DATE:	CONTRACT PMT:	MORTGAGE PMT:
❑ Rent ❑ Own		PURCHASE PRICE:	DATE PURCHASE:	BALANCE DUE:	ESTIMATED VALUE:

ASSETS/RESOURCES
Assets that are counted include: cash, checking and savings accounts, recreational vehicles, real estate other than the home or land you live on, a life insurance policy with a cash surrender value, stocks and bonds.

TYPE OF ASSET	HOUSEHOLD MEMBER	AMOUNT	PERIOD	BANK/ DESCRIPTION

CREDIT/RECURRING ACCOUNTS NAME AND ADDRESS OF CREDITOR	WHAT WAS PURCHASED	AMOUNT FINANCED	UNPAID BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				

CHILD SUPPORT EXPENSES HOUSEHOLD MEMBER MAKING PAYMENT	CHILD NAME	AMOUNT	PERIOD
1.			
2.			

Are you seeking financial assistance for treatment related to: ❑ Workplace injury ❑ Accident ❑ Crime ❑ Cancer
If yes, please provide details