Mercy Hospital and Trauma Center, Mercy Walworth Hospital and Medical Center, and Mercy Harvard Hospital

Dear Applicant:

Thank you for your interest in Mercyhealth's Community Care Program. Mercyhealth's Community Care Program is our Traditional Charity Program under Mercyhealth Financial Assistance Policy. Mercyhealth is proud to partner with those patients who are uninsured or insured but experiencing financial difficulty. Mercyhealth's Community Care Program is not an insurance policy or meant to be an alternative to health insurance or government assistance programs. If you qualify, you may have free or reduced fees for medical services or be eligible for extended payment plans. Mercyhealth will work out a payment plan based on your ability to pay. We ask that you honor this payment plan.

You may be required to meet with a Mercyhealth Patient Financial Counselor (PFC) or Customer Service Representative (CSR). We will help to determine eligibility for government or other financial resources. We can also assist in completing the application and answer any questions you may have.

Mercyhealth's Community Care Program will cover services provided by Mercyhealth only. Medically necessary services will be covered under the Community Care Program. Elective, investigational and non-medically necessary services are not covered under the Program.

In order to assess your situation you must complete the application in its entirety, including signature(s). You must also include:

- ☐ Copy of Federal Income Tax Return for the most recent tax year, including all schedules filed with the original return.
- ☐ Copies of the most recent income information for each person in the household including pay stubs, Social Security, unemployment, retirement, pensions etc.
- ☐ Copies of bank statements for both checking and savings for the last two months.
- ☐ If the household is receiving assistance from family or friends, a statement from the assisting party.
- ☐ If you are unable to work, you must apply for Social Security Disability and provide documentation that the application is being processed.
- ☐ Verification that you have applied for all medical-related resources
  - _____ **Medical Assistance**
    Rock County (608) 741-3400; Walworth County (262) 741-3200; McHenry County (815) 338-0234
  - _____ **Family Planning**
    For women ages 15-45 without health insurance, for birth control assistance
    Rock County (608) 741-3488; Walworth County (262) 741-3200; McHenry County (815) 338-0234
  - _____ **HealthNet of Janesville, Inc.**
    For Rock County residents with no health insurance and must meet income guidelines (608)756-4638
  - _____ **Open Arms Free Clinic**, **Elkhorn, WI**
    For Walworth County residents with no health insurance and meets income guidelines (262) 379-1401
  - _____ **Wisconsin Well Woman Program** Free health screenings for women ages 45-64; Rock County (608) 755-2476, Walworth County (262) 741-3200
  - _____ **Seniorcare**
    For prescription drug assistance for seniors age 65 and older (800) 657-2038
  - _____ **Emergency Medical Assistance**
    For emergency services for Non-Citizens; Rock County (888) 794-5780, McHenry County (815) 338-0234, Walworth County (888) 446-1239

- ☐ Denial and appeal documentation from any liability insurance if involved in an accident or assault
- ☐ If you are a college student, you must supply documentation of current student status.

Without the above listed items, we will not be able to process the application. If you have questions, please contact the person listed below or contact Mercyhealth Customer Service at 1-866-269-7115 or 1-608-741-7630. We look forward to assisting you.

PFC or CSR Signature: ____ Date: ______________

COMMUNITY CARE FINANCIAL ASSISTANCE APPLICATION

General Information

APPLICANT LAST NAME		PATIENT FIRST NAME	MI	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY STATE ZIP		E-MAIL ADDRESS
DATE OF BIRTH	TELEPHONE – HOME	TELEPHONE – WORK		TELEPHONE - CELL
SPOUSE'S NAME				DATE OF BIRTH

Employment Information

APPLICANT

EMPLOYMENT STATUS: (CHECK BOX)
☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED
☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: ______________________
IF EMPLOYED:
EMPLOYER NAME: ______________________
EMPLOYER ADDRESS: ______________________
EMPLOYER PHONE #:______________________
OCCUPATION: ______________________
DATE HIRED:_________________ SALARY $______________
IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER?
☐ YES ☐ NO
IF YES, DO YOU RECEIVE THIS INSURANCE
☐ YES ☐ NO IF YES, CARRIER:______________________
IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY

IF UNEMPLOYED:
UNEMPLOYEMENT BENEFITS $___________________________/WEEK
DATE UNEMPLOYED:____
REASON FOR UNEMPLOYEMENT:______________________________

SPOUSE

EMPLOYMENT STATUS: (CHECK BOX)
☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED
☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: ______________________
IF EMPLOYED:
EMPLOYER NAME: ______________________
EMPLOYER ADDRESS: ______________________
EMPLOYER PHONE #:______________________
OCCUPATION: ______________________
DATE HIRED:_________________ SALARY $______________
IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER?
☐ YES ☐ NO
IF YES, DO YOU RECEIVE THIS INSURANCE
☐ YES ☐ NO IF YES, CARRIER:______________________
IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY

IF UNEMPLOYED:
UNEMPLOYEMENT BENEFITS $___________________________/WEEK
DATE UNEMPLOYED:____
REASON FOR UNEMPLOYEMENT:______________________________

Household Information- Please list all people living at your address (even if they are not applying for assistance)

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO APPLICANT	SOURCE OF INCOME (SSI, SSDI, WORKERS COMPENSATION, CHILD/FAMILY SUPPORT, VETERANS BENEFITS, RENTAL, SUPPORT FROM FRIENDS/FAMILY, OTHER)	MONTHLY AMOUNT

Assets (Attach other if necessary)	Monthly Expenses (Attach other if necessary)	
CHECKING ACCOUNT BALANCE $	MORTGAGE/RENT $	MORTGAGE LOAN BALANCE $
SAVINGS ACCOUNT BALANCE $	AUTO LOAN $	AUTO LOAN BALANCE $
CASH ON HAND (NOT IN BANK) $	GAS $	ELECTRIC $
VALUE OF HOME $	PHONE $	CABLE/SATELLITE $
OTHER REAL ESTATE $	CREDIT CARD (S) $	OTHER LOAN $
STOCKS, BONDS, CDs $	CHILD CARE $	OTHER $
VEHICLE MAKE/TYPE/YEAR	CHILD SUPPORT $	INSURANCE PREMIUM $
OTHER ASSETS $	OTHER COURT ORDERED $	MONTHLY FOOD $

Reason for Application (include any special circumstances, e.g. extraordinary medical expenses that Mercyhealth should consider. Attach additional pages if necessary)

I authorize the Mercyhealth Community Care Program to obtain any financial information held by the Social Security Administration, County Social Services, Credit Bureaus, lending institutions, other financial institutions and/or insurance companies on myself and my family, for the purpose of determining eligibility for Mercyhealth Community Care funding. This authorization is valid for one (1) year from my dated signature. I can revoke it at any time in writing, except to the extent that Mercyhealth has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original. I hereby certify that the information is correct and complete to the best of my knowledge.

Signature of Applicant: ____ Date ____________________

If signed by a person other than the applicant, complete the following and provide documentation, if necessary.

Signature of legally authorized person: ____ Date:____________________
Applicant is: ☐ Minor ☐ Disabled ☐ Legal Guardian

You may receive a copy of Mercyhealth's Financial Assistance Policy. You may also receive help with an application or return a completed application and supporting documents to:

MercyCare Building
580 N. Washington Street-Customer Service Department
PO BOX 5003
Janesville, WI 53547
(608) 741-7630 or toll free (866) 269-7115
e-mail: custserv@mhsjvl.org
Monday through Friday 8am to 4:30pm
Or on our website at www.mercyhealthsystem.org