

Helping Hand Financial Assistance Application *For The Uninsured*

Thank you for your interest in our Helping Hand Financial Assistance Program *For The Uninsured*. We'd like to better understand your needs and find out whether you qualify for financial help on your Aurora Health Care balance(s). *Be aware that this is not an insurance policy.* To see if you qualify we ask that you:

- ✓ Fill out the enclosed 3-part application (You fill out Parts 1 and 2, and the Checklist & Certification area); if someone is supporting you or helping you financially, that person should fill out Part 3)
- ✓ Attach your 2008 Federal Tax Return (all pages).
- ✓ Attach copies of all documents that give us proof of all income received for you and your spouse (See Part 2) for 2008 and 2009.
- ✓ If you aren't required to file taxes, attach copies of all documents that give us proof of all income received for you and your spouse (See Part 2) for 2008 and 2009.
- ✓ Return the completed application and all documents to us within 2 weeks

We are here to help! Please call us if you have any questions while filling out your financial aid application and gathering your documents. Call us at 1-866-244-0883.

Sincerely,

Aurora Health Care
Central Business Office

Please Note!

The following are not eligible for Helping Hand financial help:

- ▶ Any unpaid account(s) that we have placed with a collection agency
- ▶ Any charges that are in litigation (legal proceedings)
- ▶ Elective surgical procedures including all related charges including fertility treatment.
- ▶ Already discounted procedures or insurance penalties
- ▶ Outstanding co-payments and deductibles
- ▶ Invoices/visits previously considered by the Helping Hand program
- ▶ Non-Aurora Health Care services
- ▶ Experimental and investigational procedures including clinical trials and /or studies

PART 2 – Your Family’s Income

(Please call us if you have questions or need help filling out this part – we’re glad to help)

1-866-244-0883 or 1-800-270-7855

Documented Proof Of All Income Is Required

- ▶ ***Attach** last year’s federal taxes, all pages, to your application when you send it in
- ▶ **If you and/or your spouse worked part or all of this year, complete the form below and,**
 - ***Attach** your and your spouse’s most recent pay stub(s) showing year-to-date income from all employers for the current year.
- ▶ **If you and/or your spouse did not work this year but received some income, complete the form below and,**
 - ***Attach** your year-to-date income received from all sources including but not limited to Unemployment, Retirement Accounts, Social Security, Disability, Student Grants, Alimony, etc.
- ▶ **If your income is zero for the year**
 - Enter zero income below. *** Attach** your annual Social Security Statement (If necessary, call Social Security at 1-800-772-1213 to request this required statement). Then sign this section and skip to Part 3.
 - Please explain how you are paying for your monthly expenses including food, shelter, etc. _____

SOURCE OF INCOME FOR 2009
(If married, both required)

YEAR-TO-DATE AMOUNT

_____	\$ _____	(* Attach year-to-date pay stub or other document as indicated above)
_____	\$ _____	(* Attach year-to-date pay stub or other document as indicated above)
_____	\$ _____	(* Attach year-to-date pay stub or other document as indicated above)

Check List and Certification

Check all that apply then sign below:

- My federal taxes, all pages, are attached (**REQUIRED**). If not, why not? _____
- My/our most recent pay stubs are attached. If not, why not? _____
- I attached my unemployment, IRA, Social Security statement, 401K, retirement, etc. income documents. If not, why not? _____
- I had zero income for the year. My Social Security Lifetime Earnings Statement or (Pebes) is attached. If not, why not? _____

I certify that to the best of my knowledge, the above information is true and accurate. I authorize Aurora Health Care to verify any information given on this application.

Patient or Responsible Party Signature

Date

PART 3 - Letter Of Financial Support

To be completed if someone is supporting you. The person providing the support should complete this part.

I, _____ certify that I am providing _____
with the following support each month: (List specific support provided, food, heat, telephone, shelter, medication,
insurance, etc. whatever is provided.)

The total monthly cost of this support for this individual is \$ _____. I do not ask or expect to be reimbursed for the monthly cost of this support from the individual named here.

I provide support to this individual because: (List the reason why you would provide financial support for this individual without the expectation of reimbursement. For example, short-term medical situation, long-term disability, unemployment, relocation, etc.)

How long have you been providing this individual the support described here? _____ (In months)

This individual has no financial means of support other than the support that I have described here. I certify that all of the information I provided is true. Therefore, I authorize Aurora Health Care to verify any information I provided.

Supporter's Name (please print): _____

Relationship to Patient: _____

Supporter's Address: _____

Supporter's Telephone: (_____) _____

Supporter's Signature: _____

Date of Signature: _____

Witness Name (please print): _____ Telephone: (_____) _____

Witness Signature (other than the patient): _____ Date _____

I understand that my signature does not make me liable or responsible for the debts of the individual I support as stated in this letter.
