

Helping Hand Assistance Application *For The Uninsured*

Thank you for your interest in our Helping Hand Assistance Program *For The Uninsured*. We'd like to better understand your needs and find out whether you qualify for 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 most recent Federal Tax Return (all pages). *We will accept W-2's as proof of income for all employers through April of the current year.*

New Enclose a letter from your/your spouse's employer(s) indicating 1) Whether insurance is offered to you and/or your spouse and if so, 2) What the cost is and what their contribution toward the premium is.

- ✓ Attach copies of all documents that give us proof of all income received for you and your spouse (See Part 2) within the last 18 months
- ✓ 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) within the last 18 months
- ✓ **DEADLINE:** *Return the completed application and all documents to us within 2 weeks – failure to provide information timely may result in a delay or a denial.*

For unemployment benefit information: Contact the Unemployment Insurance office 1- 800-494-4944, go the website to get year to date information <http://dwd.wisconsin.gov/uiben>

For copies of tax information: Contact the IRS office number 1-800-908-9946. To order a transcript online, go to www.irs.gov and type "Order a transcript" in the search field.

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, all insurance penalties and denials for services performed in non-covered facilities
- ▶ Some durable medical equipment, supplies, etc.
- ▶ 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

Note: This is not intended to be a complete list

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 1-800-326-2250

Sincerely,
Aurora Health Care
Germantown Business Office



Helping Hand Assistance Application

PLEASE RETURN COMPLETED 3-PART APPLICATION TO:
Aurora Health Care-Helping Hand Program
W180 N11070 River Lane
Germantown, WI 53022

Complete Parts 1&2 of this application. If someone is financially helping you, they must complete Part 3.

PART 1 – General Information About Your Family

Your Name _____
First Middle Last e-mail address

Spouses _____
First Middle Last e-mail address

Address _____
Number & Street City State Zip Code Phone Number

Your Social Security # _____ Your Date of Birth _____

Spouse's Social Security # _____ Spouse's Date of Birth _____

CHECK ALL THAT APPLY FOR NUMBERS 1 thru 5 BELOW

1. I AM CURRENTLY EMPLOYED AT _____ Pay Rate/Hour \$ _____

Occupation/Job _____ Employed From (date) _____ to _____

MY SPOUSE IS EMPLOYED AT _____ Pay Rate/Hour \$ _____

Occupation/Job _____ Employed From (date) _____ to _____

(Please be sure to include all employers you are currently employed with using the reverse for additional employer detail)

2. REGARDING INSURANCE (check all that apply:

My My Spouse's
Employer offers health insurance coverage and I am covered by the plan (please enclose a copy of both sides of your insurance card)

My My Spouse's
Employer offers health insurance coverage but I did not sign up (Please explain why and, you **must** enclose a letter from the employer(s) indicating the total cost of insurance and the amount/percent they contribute toward the employee premiums).

My My Spouse's
Employer does not offer health insurance (You **must** enclose a letter from your employer stating this)

3. LIST OF MY PREVIOUS EMPLOYERS (IF ANY) FROM 2010 TO MY PRESENT EMPLOYER

. Previous Employer _____ Employed From (date) _____ to _____

(Use reverse for additional employer details)

4. I AM NOT EMPLOYED MY SPOUSE IS NOT EMPLOYED

(Please explain why not employed including dates, reasons, last date worked, etc) _____

5. I AM RECEIVING UNEMPLOYMENT BENEFITS SINCE _____ (DATE) \$ _____ YTD Amount

MY SPOUSE IS RECEIVING UNEMPLOYMENT BENEFITS SINCE _____ \$ _____ YTD Amount

Part 1-A My Dependents

Dependents (list each by name and age) _____ Name Age Name Age

List additional dependents on the back _____

PART 2 – Your Family’s Income



Documented Proof Of All Income Is Required

Definition: Income includes all money received from any source.

Definition: Source of income means where the money is coming from or, who is paying the money to you.

For example, you might receive money from: Social Security, your employer, your spouse’s employer, a retirement fund, alimony payments, a distribution you took out from a retirement or investment fund, disability pay, unemployment compensation, etc.

Question: What if my income was zero for the year?



Answer : You must enter zero as your income below **AND** Please explain how you are paying for your monthly expenses including food, shelter, etc. _____

Then, sign this section and skip to Part 3.

TOTAL GROSS INCOME FOR 2011: \$ _____ (enclose 2011 Federal Taxes, all pages)

SOURCE OF INCOME FOR 2012

2012 YEAR-TO-DATE GROSS AMOUNT

(If married, both required)

_____ \$ _____ (You must **attach** year-to-date proof of income for each source)

_____ \$ _____ (You must **attach** year-to-date proof of income for each source)

_____ \$ _____ (You must **attach** year-to-date proof of income for each source)

_____ \$ _____ (You must **attach** year-to-date proof of income for each source)

NOTE: If self-employed, please provide your quarterly self employment benefit info.

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 enclosed letters from all of our employers indicating whether or not they offer insurance and if so, what the total premium is and what the employer contribution is.
- I attached my unemployment, IRA, Social Security statement, 401K, retirement, etc. income documents. If not, why not? _____
- I had zero income for the year **and** I answered how I am supporting myself without an income.

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 provided 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.
