

Hardship Discount Application

Hardship Overview

The information requested in this application is required to determine eligibility for a Hardship Discount. The Hardship Discount program is for insured or uninsured patients who are over the income limit for Financial Assistance. Eligibility is based on balances due for services received at Aurora Health Care in comparison to the patient's household income.

Requirements to Apply for the Hardship Discount

To be considered for the Hardship Discount, the patient must meet the following requirements:

- Resident of Wisconsin
- The patient must fully cooperate with the Hardship review process. If additional information and/or proof documents are needed to complete the application, a letter will be mailed to the patient to let them know what is needed and the deadline to submit. If the information requested is not received by the deadline, the patient will not be eligible.

What to Expect: The Eligibility Review Process

Eligibility will be determined in a timely manner from the date the application is received by the Financial Assistance Team at Aurora Health Care. Once the eligibility review is complete, a letter will be mailed to the patient to let them know if they have been approved or denied.

Please complete all 3 pages of this form. Filling out this form completely will help to prevent delays in the review process.

Patient Information			
Patient Name	Social Security#	Date of Birth	Account#

Applicant Information				
Applicant Name	Relationship to Patient	Social Security#	Date of Birth	Marital Status
Address		City, State and Zip Code		
Home Phone#	Cell Phone#	Emergency Contact Name	Emergency Contact Phone#	
Employer Name	Employer Address		Work Phone	

NOTE: If the address where you receive mail is different from the address where you live, please fill out the 'mailing address' information below

Mailing Address	City, State and Zip Code
-----------------	--------------------------

Health Insurance Information				
<input type="checkbox"/> Check this box if the patient <u>does not</u> have any source of health insurance coverage				
Health Insurance Provider	Policy Holder Name	Policy#	Group#	Effective Date
Has a member of the household lost their job within the past 60 days?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she receive a COBRA election notice?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did he/she elect COBRA coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
If he/she did not elect COBRA coverage, please check one: <input type="checkbox"/> COBRA premiums too expensive <input type="checkbox"/> has new coverage				

Please list all household members below				
Name	Social Security#	Date of Birth	Relationship to Patient	
1				
2				
3				
4				
5				
6				

NOTE: Please list any additional members of the household in the 'notes' section on page 3 of this form

Monthly Household Income		
Type of Income	Monthly Gross Income for Applicant	Monthly Gross Income for Applicant's Spouse
Employment Income	\$	\$
Retirement/Pension/Social Security Retirement	\$	\$
Social Security Disability Income	\$	\$
Unemployment Income	\$	\$
Child Support/Alimony	\$	\$
Other (list source here _____)	\$	\$

