Aurora Health Care®

For Internal Business Purposes Only
Application given to patient by: Name _____ Site/Location _____Department_____

Helping Hand Assistance Application

Aurora Health Care-Helping Hand Program
P.O. Box 511156
New Berlin WI 53151-1156

We are here to help! Please call us if you have any questions while filling out your application and gathering your documents. Call us at 1-800-326-2250

Mail completed application to the above address with all required documentation. **Please print clearly and legibly.**

PART 1 – General Information

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 _____

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 the insurance card)

___ Employer offers health insurance coverage but I did not sign up. Why _____
*(You **must enclose a letter** from the employer(s) indicating the total cost of insurance and the amount/percentage they contribute toward the employee premiums).*

___ Employer does not offer health insurance *(You **must enclose a letter** from your employer stating this)*

3. ☐ LIST OF MY PREVIOUS EMPLOYERS (IF ANY) FOR THE PAST 2 YEARS TO MY PRESENT EMPLOYER

Previous Employer _____ Employed From (date) _____to_____

(Use reverse side 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

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

Part 1-A My Dependents

	Name	Age	Name	Age
Dependents (list each by name and 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.

Examples: *Social Security, wages from your employer, your spouse's employer, a retirement fund, alimony payments, a retirement of investment fund distribution, disability pay, unemployment compensation, etc.*

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

Answer: You must enter zero as your income below**.**
If someone is supporting you, please fill our part 3 and have it signed and notarized.

TOTAL GROSS INCOME FOR PRIOR YEAR: $ _____
(Enclose copy of Federal Taxes, all pages)

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.

SOURCE OF INCOME FOR CURRENT YEAR (If married, both required) **YEAR-TO-DATE GROSS AMOUNT**

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

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_____ $_____ (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:

☐ **I am a permanent WI Resident** ***(proof of residency will be required if data on application cannot be validated)***

☐ **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 my employer or my spouses indicating whether or not they offer insurance and if so, what the total premium amount is and what the employer contribution amount 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 the Letter of Financial Support (Part 3) is Signed, Notarized & included***

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 Printed Name and 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 (patient name)_____

with the following support each month: (List specific support provided, food, heat, telephone, shelter, etc.)

_____

_____

_____

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. Examples: 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 Name_____
First Middle Last Relationship to Applicant

Address _____(_____)_____
Number & Street City State Zip Code Phone Number

Supporter's Signature: _____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

Your signature must be validated by a currently commissioned Notary Public in the State of Wisconsin. Both signature and seal are required.

Attested before me on this _____day of ___, 20___ at _____, County of _____, Wisconsin

_____ SEAL
Signature of Notary

My Commission Expires _____