Stoughton Hospital

Trusted care. Close to home.

Financial Assistance

To see if you qualify, please follow the instructions below.

If you already receive help from a state program (like Food Stamps or WIC), just fill out page one of the application and send it in with proof that you are in one of these programs. You may qualify for automatic participation in our program. Be sure to sign the last page of the application.

Be sure to give full information for everyone living in your home, and complete the three sections on the right side of the form. If you don't return complete information, your request can not be processed. All information will be kept private.

We can help with this form if you have questions.

- **If you are in the hospital, ask for one of our Patient Financial Services Counselors.**
- **If you are at home, call (608) 873-2257**

Important Notes

Our team members may try to find out if you qualify for other federal or state assistance programs prior to processing your request for Financial Assistance from Stoughton Hospital.

Financial assistance is only available for medically necessary services provided by Stoughton Hospital Association, as outlined in the Financial Assistance Policy. If you would like to learn more about this policy, please visit www.stoughtonhospital.com/fa.

If you have more questions about your bill, please call our Patient Financial Services department at (608) 873-2257.

*At **Stoughton Hospital**, we understand our patients may not be able to pay for necessary medical services. Our Community Care Program is designed to help those that qualify meet their financial responsibility for medical services they have received.*

Complete all three (3) sections

1. **Financial Assistance Application**

   Fill this attached form out completely, please remember to sign the bottom of page two.

2. **Proof of Income for everyone in your home:**

   Send copies of all items listed below that apply:

   - ☐ Tax return for last year
   - ☐ If you are employed: a pay stub with year-to-date income OR your last three (3) pay stubs
   - ☐ If you are self-employed: balance sheet and income statement
   - ☐ Monthly pension amount letter
   - ☐ Disability income amount letter
   - ☐ Social security income amount letter
   - ☐ Proof of income from rent
   - ☐ Proof of income from child support
   - ☐ Proof of income from alimony
   - ☐ If you have NO income, written statement from the person who supports you

3. **Proof of Assets for everyone in your home:**

   Send copies of all items listed below that apply:

   - ☐ Bank statements from the last three (3) months
   - ☐ Investment statements (401K, IRA, investment account, health savings account)

Financial Assistance Application

Reason You Need Help With Bill

_____

_____

_____

_____

_____

Patient Information

Name _____ Phone _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Birthday _____ Age_____ Soc.Sec.# _____ Marital Status _____

Person Responsible for Payment

Name _____ Phone _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Birthday _____ Age_____ Soc.Sec.# _____ Marital Status _____

Employer _____ Phone _____

Address _____
(Street) (City) (State) (Zip)

Job Title_____ Job Status: ☐ PT ☐ FT Avg Weekly Hours _____

Second Employer _____ Phone _____

Address _____
(Street) (City) (State) (Zip)

Job Title_____ Job Status: ☐ PT ☐ FT Avg Weekly Hours _____

Other Information

List all other people living in the household.

Name Relationship Social Security # Birth Date

_____

_____

_____

_____

Income			
Source of Income	Amount Received	How Often Received	Recipient
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Comp/Unemployment			
Interest/Dividend			
Other (Explain)			

Assets		
Item	Account Balance	Description
Checking Account		
Saving Account		
Stocks/Bonds/CDs		
401(K)/IRA/Health Savings Account		
Motor Vehicles (Make & Model/Year)		
Main Home (assessed value)		
Other Property Owned		
Total Assets (Lines 1-7)		

Expenses			
Item	Total Amount Owed	Monthly Payments	Description
Home Mortgage			
Rent (Monthly Payment)			
Utilities (Elec, Water, etc.)			
Medical Bills			
Alimony/Child Support			
Prescription Medicine			
Bank Loans (Car)			
Bank Loans (Personal, Student, etc.)			
Insurance (Auto, Health, etc.)			
Credit Card Debt			
Other (Explain)			
Total Liabilities (Lines 1-11)			

CONSENT FOR RELEASE OF INFORMATION

I certify all information is true and correct to the best of my knowledge. I understand that provision of any false or misleading claims, statements, documents or concealment or material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Stoughton Hospital, and representatives to investigate the information contained herein.

I also agree to notify Stoughton Hospital of any changes in my financial situation that would impact this determination.

_____

(Preparer's Signature) (Date)

_____

(Preparer's Signature) (Date)

Your complete application and all supporting documents* may be submitted via:

Mail:
Stoughton Hospital
Patient Financial Services
900 Ridge Street, Stoughton, WI 53589

Email:
stobilling1@stohosp.com

Fax:
(608) 873-2255

Do not mail original documents. Send copies only.