STOUGHTON HEALTH

Creating Excellence Together

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 Health.

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

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

*At **Stoughton Health**, 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 Health, and representatives to investigate the information contained herein.

I also agree to notify Stoughton Health 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 Health
Patient Financial Services
900 Ridge Street, Stoughton, WI 53589

Email:
stobilling1@stohosp.com

Fax:
(608) 873-2255

SH Form No. 6040

Do not mail original documents. Send copies only.

Plain Language Financial Assistance Policy Summary

Stoughton Health is committed to providing financial assistance to people who are without insurance, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care. Stoughton Health will provide care of emergency medical conditions to individuals regardless of their ability to pay. Stoughton Health does not want a person's ability to pay their bills to stop them from getting care. This is a summary of Stoughton Health's Financial Assistance Policy (FAP).

Availability of Financial Assistance

You may be able to get financial assistance if you are not able to pay your health care bill. Stoughton Health gives financial assistance for required medical services. Optional services, such as cosmetics, will not receive financial assistance.

Eligibility Requirements

Total income of the people living in the home and number of family members is used to determine if you get assistance. Financial need does not consider age, gender, race, social or immigrant status, sexual orientation or religious affiliation. Financial assistance is available on a sliding scale. Stoughton Health limits the amount charged for emergency and medically necessary care provided to patients who are eligible for financial assistance under this policy to not more than amounts generally billed to individuals who have insurance, and may be eligible for additional discounts.

Where to Find Information

There are many ways to find information about the FAP application process or get free copies of the FAP or FAP application form. To apply for financial assistance you may:

- Download the information online at www.stoughtonhealth.com/FAP
- Request the information in writing by fax or mail to: Stoughton Health Patient Financial Services, 900 Ridge Street, Stoughton WI 53589, fax number 608-873-2255, or by visiting the Stoughton Health Registration or Patient Financial Services departments
- Request the information by calling the Stoughton Health Patient Financial Services Department at 608-873-2257.

Availability of Translations

The Financial Assistance Policy, application form, and plain language summary can be offered in Spanish and Albanian. Stoughton Health may elect to use translation aides, or use a qualified bilingual interpreter by request. For information about translation of Stoughton Health's Financial Assistance forms, please go to the Stoughton Health Registration Department.

How to Apply

You will need to fill out a financial assistance form. The completed form and requested documents will need to be sent to Stoughton Health to review. If you need help with the form, you may contact the Stoughton Health Patient Financial services Department at 608-873-2257. When done, the application and requested documents should be delivered, mailed or faxed to: Stoughton Health Patient Financial Services, 900 Ridge Street, Stoughton WI 3589 or fax to 608-873-2255.