bellinhealth

Instructions for Completing the Community Care Application

Please read instructions carefully.

When filling out the Community Care Application we ask that you put a line in any blank that does not pertain to you or your family. Be sure to fill out all pages, including the date and your signature. After receiving all information, your application will be evaluated and you can expect a written response within 3 weeks of the results to your application. If additional information is needed a written statement requesting information will be sent to you and we request a response within 10 business days.

All of the following items listed below must be included with the application. Please provide copies of the following items for you and your spouse/life partner:

- ☐ Most recent Federal/State income tax forms
- ☐ Paycheck/Unemployment check stubs (past 3 months), written statement of earnings, or gross earnings from your employer (past 3 months)
- ☐ Forms approving or denying Unemployment, Workers Compensation, or Assistance from the Department of Public Aid
- ☐ Statement of annual benefits from Social Security
- ☐ Checking/Savings account statements (past 3 months) – monthly statements must be complete with bank or credit union name, your name, and include all pages
- ☐ Documentation/Verification of other programs such as but not limited to WIC, WI Food Share Program, WI Free/Reduced Lunch, Low Income Housing, and Energy Assistance

Your cooperation with Bellin Health is extremely important in determining your eligibility for financial assistance. All other sources of funding must be considered before Community Care will be available. Failure to cooperate will be cause to deny financial assistance.

NOTE: THIS DOES NOT MEAN BELLIN HEALTH WILL BE ADJUSTING BILLS WITH OTHER AGENCIES OR PROVIDERS – PLEASE CONTACT THEIR OFFICE.

Please submit the completed application and all information to:

Bellin Health Business Office
Attn: Community Care Specialists
PO Box 22487
Green Bay, WI 54305-2487

Or, you can bring papers to our office at 617 S. Roosevelt St., Green Bay, WI
Monday through Friday, 8 a.m. to 4:30 p.m.

If you have any questions, please call (920) 433-3712
or fax information to (920) 593-2519, or e-mail patientfinancial@bellin.org.

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P.O. Box 22487, Green Bay, WI 54305-2487

COMMUNITY CARE APPLICATION

Please read the instruction letter included with this application.

Guarantor Name (person who pays the bill) _____
Last First MI

Address _____ City/State _____ Zip _____

Phone Number (Home) _____ (Work) _____ (Cell) _____

Birth Date _____

Marital Status: ☐ Married ☐ Single ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widow

Patient Name (if different than guarantor) _____ Birth Date _____
Last First MI

Does any of the information below apply to you? If YES, check all that apply. **Please provide documentation/verification if you check YES to any of the statements below:**

- ☐ Homeless
- ☐ Referred to Bellin by a free clinic program

Are you enrolled in any of the programs below? **Please provide documentation/verification if you check YES to any of the options below:**

- ☐ Woman, Infants, and Children Nutrition Program (WIC)
- ☐ WI Food Share Program
- ☐ Wisconsin Free/Reduced Lunch Program
- ☐ Low Income Home Energy Assistance Program (LIHEAP)
- ☐ Wisconsin Home Energy Assistance Program (WHEAP)
- ☐ Housing Allowance

Did you file Federal and State taxes for the previous year? ☐ Y ☐ N

Total household size is determined as yourself, spouse/life partner, and all dependent children age 17 or less for whom a taxpayer is allowed a deduction on their federal tax return.

How many? _____

Total household income is determined as yourself and spouse/life partner. How much? _____

Complete the back of the application and send all supporting documentation to:

Bellin Health Business Office
ATTN: Community Care Specialist
PO Box 22487
Green Bay, WI 54305-2487

Guarantor Income (person who pays the bill)

Are you currently employed? ☐ Y ☐ N Employer _____ Start Date _____

Are you retired? ☐ Y ☐ N

If unemployed, date of last employment _____

Other Income (VA benefits, trust income, 2nd job) $ _____

Social Security $ _____

Disability $ _____ Pension $ _____

Unemployment Compensation $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Alimony/Maintenance $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Child Support $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Do you have an HRA, HSA, or Flex Spend Account? ☐ Y ☐ N How much is in your account? _____

Do you have a medical cost sharing program? ☐ Y ☐ N Program you belong to? _____

Spouse/Life Partner

Name _____
Last First MI

Employer _____ Start Date _____

Date of Birth _____

Are they retired? ☐ Y ☐ N

Social Security $ _____

Disability $ _____ Pension $ _____

If unemployed, date of last employment _____

Unemployment Compensation $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Alimony/Maintenance $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Child Support $ _____ ☐ Bi-Weekly ☐ Weekly ☐ Monthly

Other Income (VA benefits, trust income, 2nd job) $ _____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.), which may be applicable for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate. I agree to work with all third-party programs prior to accepting Community Care.

Date of Request _____ Applicant's Signature _____