FINANCIAL ASSISTANCE APPLICATION

Spooner Health, 1280 Chandler Drive, Spooner, WI 54801
Telephone: 715-939-1609 Fax: 715-939-1558

Medical Record #: _____ Account #('s):_____

Date(s) of Service: _____

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members:

Patient's Name: _____ Social Security #: _____

Address: _____

Home Telephone #: _____ Work Telephone #: _____

Employer Information (Patient/Responsible Party):

_____

Total # of Household Members: _____

List ALL Household Members Name:

Name	Date of Birth	Social Security Number	Relationship to Patient	Monthly Income

HAVE YOU APPLIED FOR WISCONSIN MEDICAL ASSISTANCE? _____YES _____NO

If so, were you denied? _____

Please include a copy of denial notification with this form.

Patient/Responsible Party Information:

MONTHLY INCOME

Gross Income (before taxes) _____
Other Household Gross Income: _____
Investment Income: _____
Child Support/Alimony _____
Rental Property Income: _____
Pension/Retirement: _____
Unemployment: _____
Other Income: _____

Total Monthly Income: _____

MONTHLY EXPENSES:

Rent: _____
Mortgage: _____
Homeowners: _____
Other: _____

Total Monthly Expenses: _____

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient. I understand that providing false information will result in denial of the application for any type of financial assistance through Spooner Health. I understand that my credit report may be used to verify this information. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Spooner Health to obtain such assistance and will assign to Spooner Health, and upon receipt, will pay Spooner Health all amounts recovered up to the total amount of the outstanding balance on my bill.

_____ _____
Signature of Patient/Responsible Party Date

PROVIDER: SPOONER HEALTH

PATIENT NAME: _____

ACCOUNT NUMBER(S): _____

MEDICAL RECORD #: _____

CURRENT BALANCE: _____

DATE(S) OF SERVICE: _____

You have been referred as a candidate for Financial Assistance. In order to complete the application, you will need to provide us with proof of the gross income for the past 12 months for ALL members of your household receiving income, along with a completed Financial Questionnaire. Proof of income includes ALL of the following:

1. Copy of previous year's Federal Tax Return: include ALL pages of the tax form OR proof of non-filing status from the IRS (800-829-1040).
2. Copy of two (2) current pay stubs or the last two (2) pay stubs received.
3. All documentation you have regarding unemployment and/or Workers Compensation, alimony, child support, WIC, Foods Stamps, and/or other financial support.
4. Letter(s) from any person(s) who support or assist you financially.
5. Copy of last 2-3 months of checking and savings bank statements.
6. Copy of Wisconsin Medicaid Eligibility Determination or denial.
   A. Link to Wisconsin Medicaid Application: https://access.wisconsin.gov
7. Completed Financial Assistance Application with signature.

Please mail all information to:

Spooner Health, Attn: Financial Counselor, 1280 Chandler Drive, Spooner, WI 54801 within 15 days.

Should you have any questions, please refer to the bottom of this letter to contact the appropriate Patient Accounts Representative.

Thank you for your cooperation in this matter.

Sincerely,

Patient Accounts Department
1280 Chandler Drive
Spooner, WI 54801
715-939-1609

PLAIN LANGUAGE SUMMARY OF FINANCIAL ASSISTANCE POLICY

Overview

It is the policy of Spooner Health (SH) to treat the broadest number of patients residing within our service area while maintaining fiscal responsibility. This is a summary of the SH Financial Assistance Policy (FAP).

Availability of Financial Assistance

Patient will be considered for charity or discounted billing based on their ability to pay and the Federal Poverty Guidelines (FPG) issued and updated annually. Charity consideration is given to emergency, inpatient, outpatient and medically necessary procedures. Financial assistance and discounts only apply to SHS bills. Any balance can be considered for charity, including balances after insurance payment. Patients must reside within the State of Wisconsin.

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on FPG. When total household income is less than 100% of FPG, a 100% discount from gross charges applies. With respect to uninsured individuals, when total household income is between 101% and 150% of FPL, a 90% discount applies; when total household income is between 151% and 200% of FPL, a 75% discount applies; when total household income is between 201% and 250% of FPL, a 50% discount applies; when total household income is between 251% and 300% of FPL, a 43% discount applies. *No person eligible for financial assistance under the FAP will be charged more for medically necessary care than amounts generally billed (AGB) to individuals who have insurance covering such care*. SH determines AGB based on all claims paid in full to SH by Medicare and private health insurers (including payments by Medicare beneficiaries or insured individuals themselves), over a 12-month period, divided by the associated gross charges for those claims. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. Please refer to full policy for a complete explanation and details.

Where to Obtain Information

There are numerous ways that an individual may obtain information about the FAP application process, or obtain copies of the FAP or FAP Application Form:

- Download the information online at www.spoonerhealth.com
- Request the information by telephone by calling the Spooner Health Patient Accounts Financial Counselor at 715-939-1609
- In person at Spooner Health, 1280 Chandler Drive Spooner, WI 54801-2202

Availability of Translations

The FAP, FAP Application Form, and this plain language summary shall be prepared in English and for any population more than either (a) 1,000 individuals or (b) 5% of the community served by the hospital.

How to Apply

The application process involves filling out the Financial Assistance form and mailing the form along with the supporting documentation to SH for processing. You may also apply in person by visiting the Patient Accounts Department at the address listed below. Financial Assistance applications are to be submitted to the following office:

Spooner Health
Attn: Patient Financial Counselor
1280 Chandler Drive
Spooner, WI 54801-2202