

MEMORIAL HOSPITAL OF LAFAYETTE COUNTY



...*"We Treat You Like Family"*

Information about Memorial Hospital of Lafayette County's Patient Financial Assistance Program "PFAP"

At Memorial Hospital, we take great pride in providing excellent, compassionate health care. We provide financial assistance to those patients unable to pay in full for needed health care services. We ask that each patient who wants to take advantage of our Patient Financial Assistance Program meet the following requirements.

- All other third party resources for which you are or may be eligible must be exhausted. This includes insurance plans, liability insurance, lawsuit settlements, workers compensation process, probate distributions, etc.
- Prior to submitting your PFAP application, please contact your County Human/Social Services Department or go online (www.badgercareplus.org) to qualify for any applicable government programs. If you are denied please include a copy of this denial with your PFAP application.
- The care you receive must be considered "essential health care". Services considered "elective" will not be eligible for PFAP.
- You must fall within our eligibility guidelines that include income, assets and expenses.

Application Guidelines

Each patient (or other interested party on behalf of the patient) must return a completed Financial Statement. A copy can be found following this notice. Please print and complete. If you cannot print, please call our Financial Coordinator at 608-776-5733 to request that one be sent to you.

You must attach the following: A copy of your most recently filed federal/state tax returns. And, if applicable, your last 3 pay stubs.

Once you have completed and compiled all of the above information, you may either drop this off in person or mail your application packet to:

Memorial Hospital of Lafayette County
Attn: Patient Financial Coordinator
800 Clay St Box 70
Darlington WI 53530

Once your application is received it will be reviewed for accuracy and completeness. If any inaccuracies, inconsistencies or missing information is discovered you will be contacted either by phone or letter requesting that the information be correct or supplied.

You will be notified in writing of acceptance or denial. Based on the criteria if denied or partially awarded, you will be asked to contact the Financial Coordinator to make arrangements of the remaining balance.

If you have any questions, please contact Patient Financial Services at 608-776-5733.

Financial Statement

Patient Information		Spouse/Responsible Party	
Patient Name:		Name:	
Address:		Address:	
Phone #:		Phone #:	
Social Security #:		Social Security #:	
Responsible Party (If under 18, complete for both parents.)			
Name:		Name:	
Address:		Address:	
Phone #:		Phone #:	
Social Security #:		Social Security #:	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a part time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School:			
Employer Information: Patient		Spouse/Responsible Party	
Employer:		Employer:	
Employer Address:		Employer Address:	
Phone #:		Phone #:	
Job Title:		Job Title:	
Length of Employment:		Length of Employment:	
Dependents		Bank	
Name:	Age:	D.O.B.	Bank Name:
			Bank Address:
			Checking Account #
			Balance \$:
			Savings Account #:
			Balance \$:
			Retirement Plan/Pension:
			Balance \$:
			Other Investments & Securities:
			Balance \$:
Property			
Residence: Own <input type="checkbox"/> Rent <input type="checkbox"/>	Estimated Value:		Balance \$:
Monthly Payments \$			
Residence:	\$		\$
Vehicles			
Year/Make	\$		\$
Year/Make	\$		\$
Land: # of acres:	\$		\$
Business:	\$		\$
Rental Property:	\$		\$
Boats	\$		\$
Motorcycle/ATV	\$		\$
Other Recreational Vehicles	\$		\$
Other Assets	\$		\$

Monthly Income		
	Source	Monthly Income
1. Patient/Parent if under 18		\$
2. Spouse/Responsible Party		\$
3. Interest/Dividends		\$
4. Pension/Disability		\$
5. Child Support/Alimony		\$
6. Other		\$
7. Total Gross Monthly Income		\$
8. FICA + Income Taxes Withheld		\$
9. Net Monthly Income		\$

Monthly Expenses		Avg Monthly Expense
10. Groceries		\$
11. Utilities		\$
12. Auto (Gas, Repairs)		\$
13. Telephone		\$
14. Cable		\$
15. Entertainment		\$
16. Child Care		\$
17. Child Support/Alimony		\$
18. Medications		\$
19. Other:		\$
		\$

Creditors			
Please indicate all other monthly payments, e.g. bank payments, credit cards, other medical, etc.			
	To Whom	Unpaid Balance	Monthly Payment
21. Rent/Mortgage		\$	\$
Original Principal Amt: \$			
22. Medical: Doctor:		\$	\$
23. Medical: Hospital		\$	\$
24. Credit Card		\$	\$
25. Credit Card		\$	\$
26. Home Equity Loan		\$	\$
27. Other		\$	\$
28. Other		\$	\$
Insurance		Annual Premium	Monthly Payment
29. Auto		\$	\$
30. Life		\$	\$
31. Health		\$	\$
32 Other		\$	\$
33. TOTAL MONTHLY EXPENSES (add lines 10 through 32)			\$
34. INCOME LESS EXPENSES (line 9 minus 33)			\$

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Memorial Hospital of Lafayette County. I hereby grant permission to Memorial Hospital of Lafayette County and representatives to investigate the information contained herein and to obtain a credit report.

SIGNATURE _____ DATE _____