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:

- 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. We use the most recent Federal Poverty Level Guidelines and include your current income and expenses.

Application Guidelines

Each patient (or other interested party on behalf of the patient) must complete and return the Financial Statement attached. **This offer expires after 15 days**. Please complete and return the Financial Statement, along with all applicable requested documents, prior to _____ or your application will be void.

The following items are requested to support your financial status:

- A copy of your most recently filed federal/state tax returns
- Your last 3 pay stubs or proof of social security payment
- The last 3 months' bank statements

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 Street
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 corrected or supplied.

You will be notified in writing of acceptance or denial. Based on the criteria, if denied or partially awarded, the letter of acceptance or denial will include the current remaining balance and the required monthly payment plan.

If you have any questions, please contact Patient Financial Services at 608-776-4466.

MEMORIAL HOSPITAL OF LAFAYETTE COUNTY

Financial Statement

Patient Information	**Spouse/Responsible Party**
Patient Name:	Name:
Address:	Address:
Phone #:	Phone #:
Social Security #:	Social Security #:
Employer:	Employer:
Employer Address:	Employer Address:
Phone #:	Phone #:
Job Title:	Job Title:
Length of Employment:	Length of Employment:
Dependents (Names & Ages):	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

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

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

MEMORIAL HOSPITAL
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Insurance	Annual Premium	Monthly Payment
21. Auto	$	$
22. Life	$	$
23. Health	$	$
24. Home	$	$
25. Other Insurance:	$	$

Creditors	Unpaid Balance	Monthly Payment
26. Mortgage	$	$
Original Principal Amount: $		
27. Home Equity Loan	$	$
28. Auto Loan	$	$
29. Medical	$	$
30. Credit Cards	$	$
31. Other Loan:	$	$

32. TOTAL MONTHLY EXPENSES (add lines 10 through 31)	$
33. INCOME LESS EXPENSES (line 9 minus 32)	$

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 _____

Attention

Memorial Hospital of Lafayette County and Primary Care Clinics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Memorial Hospital of Lafayette County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak any of the below languages, language assistance services, free of charge, are available to you.

Spanish- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Hmong- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

Chinese-注意：如果您使用繁體中文，您可以免費獲得語言援助服務

German- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

Arabic- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

Russian- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Korean-주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

Vitnamese- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Pennsylvanian Dutch- Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch.

Loatian- ໂປດຊາບ: ຖ້າວ່າ ທ່ ານ ເວ້ າພາສາ ລາວ, ການບໍລ ການຊ ່ ວຍເຫ ຼ ອດ້ ານພາສາ, ໂດຍ
ບ ່ ເສ ັ ຽ ຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ.

French- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Polish- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

Hindi- ध्यान दें: यदद आप द ंदी बोलते ं तो आपके ललए मफ्ु त मेंभाषा स ायता सेवाएिउपलब्ध ं।

Albanian- KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.

Tagalog- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.