

Dear

As your partner in healthcare, Aspirus is committed to providing quality healthcare. For patients in certain financial situations, we have a program called Aspirus Community Care.

Aspirus Community Care is a financial assistance program. It is not a Health Insurance Plan. You may be responsible for part of your bill, and you will need to arrange a payment plan for any non-covered part of your bill. Aspirus Community Care does not cover charges for all of your doctors at Aspirus such as your Radiologist, Pathologist, or Anesthesiologist.

To apply for Aspirus Community Care, please provide all of the following information:

1. Complete the Aspirus Community Care form.
2. **Return the form within 10 days from the date of this letter and include all of the necessary information.** If any information is missing, we are not able to consider your application.
3. If you or a family member is under 18, over 65, blind, disabled, or pregnant, you, or they may be eligible for Medical Assistance. If you want to be considered for Aspirus Community Care, you must have applied for Medical Assistance and been denied. You will need to provide evidence of denial. Please contact the Social Services Department in the County in which you live to apply for Medical Assistance.
4. Please attach the following:
 - a. Photocopy of last year's Federal tax return
 - b. Photocopy of your Social Security check
 - c. Current bank statements showing your deposits and withdrawals
 - d. Your last pay stub showing your year-to-date income
 - e. Proof of your Unemployment Income
 - f. If self-employed, provide year-to-date income
5. Attach copy(s) of your most recent property tax bill(s) for any real estate property you own, and a copy of your mortgage statement(s).
6. Attach proof of last year's child support payments from the Child Support Agency for your county if you are receiving child support. If you are not receiving child support and should be, attach a letter stating that the court has been unable to collect from the responsible party.
7. Sign and date the form.
8. If you have no source of income, please provide a letter of support from whoever provides for your living expenses.

If you have any questions, please call us at (715) 847-2137 or (800) 283-2881 ext. 72137. You will receive a written reply if you qualify for Aspirus Community Care within 30 days.



Financial Disclosure APPLICATION

AWH _____
 ACI _____
 LH _____

Current charges Yes No Pre-approved for future visits Yes No

333 Pine Ridge Boulevard ~ Wausau, WI 54401
 P 715.847.2121 ~ F 715.847.2017 ~ aspirus.org

Patient Name: _____ Age _____ Date of Birth _____ SS#: _____
 Person Responsible for Bill: _____ Spouse Name if Applicable: _____
 Name: _____ Age _____ Name: _____ Age _____
 Date of Birth _____ Date of Birth _____
 Address: _____ Address: _____

 Phone No _____ Work No. _____ Social Security # _____
 Social Security # _____

Marital Status(circle one): Single Married Widowed Separated Divorced

Dependent's Name(s)	Age	Relationship	Date of Birth
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

Employer: _____	Employer: _____
Part Time: _____ Full Time: _____	Part Time: _____ Full Time: _____
Business Phone: _____	Business Phone: _____
Gross Earnings: _____	Gross Earnings: _____
Hr _____ Wk. _____ Mo. _____	Hr _____ Wk. _____ Mo. _____

If unemployed, list date of unemployment: _____

Do you have any income or balance from any of the items below? (Circle one)

Please provide verification of dollar amounts listed.

Social Security	Yes	No	_____	Health Savings Account	Yes	No	_____
Veterans Benefits	Yes	No	_____	Checking Account	Yes	No	_____
Workers Compensation	Yes	No	_____	Savings Account	Yes	No	_____
Unemployment	Yes	No	_____	Stocks or Bonds	Yes	No	_____
Interest/Dividends	Yes	No	_____	Other Savings	Yes	No	_____
Alimony or Support	Yes	No	_____	Rental Property	Yes	No	_____
				Certificate of Deposit	Yes	No	_____

Name of Banks: 1. _____ 2. _____
 Address: _____

Do you own or rent your place of residence? Own _____ Rent _____

Real Estate Value: _____ Balance of Mortgage: _____

Copy of Property Tax Statement must be attached.

ASSETS/PROPERTY	Asset	Value	Lien Holder	Loan Balance	Monthly Payment
Motor Vehicles	Year/Make /Model	\$		\$	\$
	Year/Make /Model	\$		\$	\$
Other Assets	Year/Make /Model	\$		\$	\$
	Year/Make /Model	\$		\$	\$
Homestead	Address	Market Value \$		\$	\$
Homestead	Address	Market Value \$		\$	\$
Other Property	Address	Market Value \$		\$	\$

Monthly Expenses

Rent \$	Water & Sewer \$	Child Care \$	Transportation Costs \$	Property Insurance \$	Property Taxes \$
Phone \$	Heat \$	Child Support/Alimony \$	Medications \$	Auto Insurance \$	Other Specify \$
Electric \$	Cable TV / Satellite \$	Food \$	Health Insurance \$	Life Insurance \$	Market Value \$

Other Debts: For example: Loans, medical bills, delinquent taxes, tax liens, judgements, credit cards.

Creditor Name	Address	Balance	Payment
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
Monthly Total			\$
Grand Total / Monthly Bills, Other Expenses, & Monthly Expenses			

***Omitting information or providing fraudulent information will be cause for permanent denial.**

I certify that all information is true to the best of my knowledge and give Aspirus permission to verify the above information and run a credit report.

I give Aspirus permission to share information contained in this application with other affiliated Aspirus entities or partners if so requested.

Signature: _____ **Date:** _____