Helping Hand Assistance Application
For the Uninsured

Thank you for your interest in our Helping Hand Assistance Program. We’d like to better understand your needs and find out whether you qualify for help on your Aurora Health Care balance(s). Be aware that the Helping Hands Assistance Program is not an insurance policy.

Eligibility Requirements:

- Patient must permanently reside in Wisconsin and be a resident within the Aurora Health Care geographical locations that Aurora Health Care provides services (this will be validated)
  - If residency cannot be confirmed, the following documents are acceptable proof of Wisconsin residency when they include your name and current Wisconsin resident street address:
    - Utility bill for water, gas, electricity or landline telephone service issued within the last 90 days.
    - Deed/title, mortgage, rental/lease agreement for WI property (lease must include landlord’s name/ phone number)
  
  Note: Documents listing a post office box or commercial receiving agency are not acceptable.

- Patient must have an established relationship with an Aurora provider
- Services may not be covered by any private or public insurance programs
- All other financial assistance options from other sources (i.e. federal, state or local programs or grants as well as private sources) must be explored prior to receiving financial assistance

Eligible Services:

- Medically necessary services related to an illness or condition.
  - Elective (i.e. cosmetic), preventive and/or routine services do not qualify

Services NOT eligible: Note: This is not intended to be a complete list

- Elective/routine/cosmetic services or procedures and all related charges including fertility treatment. Services must be for the treatment of an illness or medical condition.
- Experimental and investigational procedures including clinical trials and/or studies
- Non-Aurora Health Care services
- Insurance penalties and/or denied services performed in non-covered facilities
- Some durable medical equipment, supplies, etc.
- Already discounted procedures
- Any unpaid account(s) that we have placed with a collection agency
- Any charges that are in litigation (legal proceedings)
- Outstanding co-payments and deductibles

Failure to provide all required information with the application will result in a denied application.

We are here to help! Please call us if you have any questions while filling out your financial aid application and gathering your documents. Call us at 1-800-326-2250
Helping Hand Assistance Application
Aurora Health Care-Helping Hand Program
P.O. Box 3193
Milwaukee, WI 53201

Mail completed application to the above address with all required documentation. Please print clearly and legibly.

PART 1 – General Information

Your Name_________________________________________________________________________________________________________
First               Middle                 Last  e-mail address
______________________________________________________________________________________________________________
First    Middle Last  e-mail address
Address_______________________________________________________________________________________________________
Number & Street             City  State   Zip Code        Phone Number
Your Social Security #____________________________________  Your Date of Birth ________________________
Spouse’s Social Security #_________________________________   Spouse’s Date of Birth ______________________
CHECK ALL THAT APPLY FOR NUMBERS 1 thru 5 BELOW
1. □ I AM CURRENTLY EMPLOYED AT ____________________________________________ Pay Rate/Hour $ _______________
   Occupation/Job _____________________________    Employed From (date)___________ to _____________
   □ MY SPOUSE IS EMPLOYED AT ____________________________________________ Pay Rate/Hour $ _______________
   Occupation/Job _____________________________    Employed From (date)___________ to _____________
2. REGARDING INSURANCE (check all that apply):
   □ My   □ My Spouse’s
   ___ Employer offers health insurance coverage and I am covered by the plan
   (Please enclose a copy of both sides of the insurance card)
   ___ Employer offers health insurance coverage but I did not sign up. Why _______________________
   (You must enclose a letter from the employer(s) indicating the total cost of insurance and the amount/percentage
   they contribute toward the employee premiums).
   ___ Employer does not offer health insurance (You must enclose a letter from your employer stating this)
3. □ LIST OF MY PREVIOUS EMPLOYERS (IF ANY) FOR THE PAST 2 YEARS TO MY PRESENT EMPLOYER
   Previous Employer __________________________________________  Employed From (date) ________to__________
   (Use reverse side for additional employer details)
4. □ I AM NOT EMPLOYED   □ MY SPOUSE IS NOT EMPLOYED
   (Please explain why not employed including dates, reasons, last date worked, etc.)
   __________________________________________________________________________
5. □ I AM RECEIVING UNEMPLOYMENT BENEFITS SINCE _______________ (DATE)    $ _____________ YTD Amount
   □ MY SPOUSE IS RECEIVING UNEMPLOYMENT BENEFITS SINCE ______________ $ _____________ YTD Amount

For unemployment benefit information: Contact the Unemployment Insurance office 1- 800-494-4944,
Or go to the WI unemployment benefit website to get year to date information http://dwd.wisconsin.gov/uiben

Part 1-A  My Dependents

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<tr>
<th>Name</th>
<th>Age</th>
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Dependents (list each by name and age) ___________________________     ___________________________
List additional dependents on the back ___________________________     ___________________________
**PART 2 – Your Family’s Income**

**Documented Proof of All Income Is Required**

**Definition:** *Income* includes all money received from any source.

**Definition:** *Source of income* means where the money is coming from or, who is paying the money to you.

*Examples:* Social Security, wages from your employer, your spouse’s employer, a retirement fund, alimony payments, a retirement of investment fund distribution, disability pay, unemployment compensation, etc.

**Question:** *What if my income was zero for the year?*

**Answer:** You must enter zero as your income below.

*If someone is supporting you, please fill our part 3 and have it signed and notarized.*

**TOTAL GROSS INCOME FOR PRIOR YEAR:** $ ________________________

*(Enclose copy of Federal Taxes, all pages)*

For copies of tax information: Contact the IRS office number 1-800-908-9946. To order a transcript online, go to www.irs.gov and type “Order a transcript” in the search field.

**SOURCE OF INCOME FOR CURRENT YEAR**

**YEAR-TO-DATE GROSS AMOUNT**

(If married, both required)

<table>
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<tr>
<th>Source of Income</th>
<th>Year-to-Date Gross Amount</th>
<th>(You must attach year-to-date proof of income for each source)</th>
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*NOTE: If self-employed, please provide your quarterly self employment benefit info.*

**Check List and Certification**

Check all that apply then sign below:

- [ ] I am a permanent WI Resident (proof of residency will be required if data on application cannot be validated)
- [ ] My federal taxes, all pages, are attached *(REQUIRED)*. If not, why not? _____________________________________________
- [ ] My/our most recent pay stubs are attached. If not, why not? _______________________________________________________
- [ ] I enclosed letters from my employer or my spouses indicating whether or not they offer insurance and if so, what the total premium amount is and what the employer contribution amount is.
- [ ] I attached my unemployment, IRA, Social Security statement, 401K, retirement, etc. income documents. If not, why not? ____________________________________________________________
- [ ] I had zero income for the year and the Letter of Financial Support *(Part 3)* is Signed, Notarized & included

*I certify that to the best of my knowledge, the above information is true and accurate. I authorize Aurora Healthcare to verify any information provided on this application.*

__________________________________________

Patient or Responsible Party Printed Name and Signature

Date
PART 3 - Letter of Financial Support

To be completed if someone is supporting you. The person providing the support should complete this part.

I, _______________________, certify that I am providing (patient name)___________________ with the following support each month: (List specific support provided, food, heat, telephone, shelter, etc.)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

The total monthly cost of this support for this individual is $___________________.

I do not ask or expect to be reimbursed for the monthly cost of this support from the individual named here.

I provide support to this individual because: (List the reason why you would provide financial support for this individual without the expectation of reimbursement. Examples: short-term medical situation, long-term disability, unemployment, relocation, etc.)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

How long have you been providing this individual the support described here? ___________ (In months)

This individual has no financial means of support other than the support that I have described here. I certify that all of the information I provided is true. Therefore, I authorize Aurora Health Care to verify any information I provided.

Supporter Name________________________________________________________________________________________________

First                                       Middle                                 Last                                      Relationship to Applicant

Address ________________________________________________________________________________( _____ )_______________

Number & Street                                     City                                      State              Zip Code                    Phone Number

Supporter's Signature: ________________________________________________________Date:  ____________________

I understand that my signature does not make me liable or responsible for the debts of the individual I support as stated in this letter.

Your signature must be validated by a currently commissioned Notary Public in the State of Wisconsin. Both signature and seal are required.

Attested before me on this ______day of ___, 20___ at ______________, County of _______________, Wisconsin

_____________________________________________________ SEAL

Signature of Notary

My Commission Expires ____________________