Wheaton Franciscan Healthcare

In recognition of Wheaton Franciscan Healthcare’s policy to provide quality health care to all persons regardless of their financial status, Wheaton Franciscan Healthcare’s Community Care program provides financial assistance to those in need in a fair, non-discriminatory manner.

Community Care Financial Application Instructions

Submit the following checked (√) Items:
(please send copies, originals will not be returned)
All information is needed for both applicant and spouse

- Copy of your most recent paycheck stub/voucher.
- Verification of monthly income from Social Security if you are retired or on disability.
  (Example: Bank Statement or Award Letter)
- Verification of unemployment income.
- Verification of child support and/or alimony.
- Verification of pension and/or work comp benefits.
- Verification of food stamps, FIP Assistance, heating and housing assistance.
- Applicants that receive financial help from a family member or other person for living expenses must include written statement from this person.
- Complete copy of your _____ calendar year signed Federal Tax Return including all schedules if you are self employed and/or have farm or rental real estate income.
- If you do not have health insurance
  1. A letter from your employer and/or your spouse’s employer, confirming health insurance coverage is not available.
  2. If you declined health insurance offered through your employer and/or your spouse’s employer, submit cost of the premiums.
- If you do have health insurance:
  1. Proof of premiums you are paying for health insurance coverage.
- Letter of decision regarding public funded health insurance coverage is required.

Please call your local Department of Human Services office to apply for Medicaid/Title 19 and/or medically needy spend down program.

Wheaton Franciscan Healthcare will submit a written response to the applicant upon receipt of a completed application and supporting information.

IF YOU HAVE QUESTIONS, PLEASE CALL 1-800-728-0159 OR 319.272.0044.
Date: __________________________  Account Number(s): __________________________________________

Applicant's Name: ______________________________________________ Patient's Name __________________

Applicant's Address: ____________________________________________ City: __________________ St: _____ Zip: __________

Applicant's Phone No: __________________________ SSN __________________ Date of Birth __________

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Spouse's Name: ____________________________________________ SSN __________________ Date of Birth __________

Dependent’s Name Date of Birth  Dependent’s Name Date of Birth
_________________________________________  _____/______/______  __________________________________  _____/______/______
_________________________________________  _____/______/______  __________________________________  _____/______/______
_________________________________________  _____/______/______  __________________________________  _____/______/______

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED):

APPLICANT

Are you presently employed? [ ] Yes [ ] No  Do you file federal tax return? [ ] Yes [ ] No

Are you self-employed? [ ] Yes [ ] No  Do you have health insurance? [ ] Yes [ ] No

Hire Date: __________________________  Monthly amount paid for health insurance: $_______

How often are you paid?: [ ] Weekly  [ ] Bi-Weekly  [ ] Monthly  Hourly Wage: $_______

How many hours are you scheduled each pay period? [ ] 20 [ ] 40 [ ] 60 [ ] 80 [ ] 120 [ ] Other_______

Present or Last Employer: ____________________________ City: __________________ State: _____

Monthly Gross Income: ____________________________ Telephone Number: ______________________

SPOUSE OF APPLICANT

Are you presently employed? [ ] Yes [ ] No  Do you file federal tax return? [ ] Yes [ ] No

Are you self-employed? [ ] Yes [ ] No  Do you have health insurance? [ ] Yes [ ] No

Hire Date: __________________________  Monthly amount paid for health insurance: $_______

How often are you paid?: [ ] Weekly  [ ] Bi-Weekly  [ ] Monthly  Hourly Wage: $_______

How many hours are you scheduled each pay period? [ ] 20 [ ] 40 [ ] 60 [ ] 80 [ ] 120 [ ] Other_______

Present or Last Employer: ____________________________ City: __________________ State: _____

Monthly Gross Income: ____________________________ Telephone Number: ______________________

OTHER SOURCES OF INCOME (check type and list amount):

☐ Alimony/Child Support ____________________________  ☐ Pension Annuity ____________________________

☐ Social Security ____________________________  ☐ Workman’s Compensation ____________________________

☐ Veteran’s Pension ____________________________  ☐ Rental Income ____________________________

☐ Unemployment Compensation ____________________________  ☐ Other (Specify) ____________________________

☐ School Grants ____________________________

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to Wheaton Franciscan Healthcare for verification of this financial statement.

Signature of Patient/Applicant Date

_________________________  __________________________

Spouse Date

_________________________  __________________________

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