Financial Assistance Policy

Plain Language Summary

At Vernon Memorial Healthcare, we understand that receiving medical care can be unexpected and may lead to a financial hardship. VMH offers a Financial Assistance Program to help you.

Eligibility

Patients with an annual family income of 250% or less of the Federal Poverty Level, and who qualify under the Financial Assistance Program guidelines, are eligible for Financial Assistance through Vernon Memorial Healthcare for services received at our hospital or clinics. Federal poverty guidelines are updated annually at www.dhs.wisconsin.gov/medicaid/fpl.htm

What is covered?

Emergency and medically necessary services provided at Vernon Memorial Healthcare, hospital and clinics, by Vernon Memorial Healthcare employed service providers. The technical component of services performed at Vernon Memorial Healthcare by a provider not employed by Vernon Memorial Healthcare may qualify under the Financial Assistance Program. The professional component of services will not qualify for Financial Assistance.

Assistance

Eligibility determination will include family income and assets. Discounted and free care is available to those who qualify for Financial Assistance.

How to apply

A patient may apply to receive financial assistance. The following application requires completion in order to qualify for assistance.

Vernon Memorial Healthcare
So much care, so close.

Vernon Memorial Healthcare
507 S. Main Street, Viroqua, WI 54665
(608) 637-2101 info@vmh.org www.vmh.org

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Vernon Memorial Healthcare, Inc.

FINANCIAL ASSISTANCE APPLICATION

PERSONAL INFORMATION

Today's Date:		Guarantor Number:
HEAD OF HOUSEHOLD PERSONAL INFORMATION:		**SPOUSE PERSONAL INFORMATION:** (IF APPLICABLE)
First Name:		
Middle Initial:		
Last Name:		
Date of Birth:		
Social Security Number:		
Street Address, City, State ZIP Code:		
Employer Name and Address:		
☐ Full-Time		☐ Full-Time
☐ Part-Time		☐ Part-Time
☐ Self-Employed ☐ Unemployed ☐ Student ☐ Retired		☐ Self-Employed ☐ Unemployed ☐ Student ☐ Retired

DEPENDENTS (IF MORE THAN 6 DEPENDENTS, USE SEPARATE PAGE)

Full Name:	Relationship:	Birth Date:	

CHECK ALL BOXES BELOW THAT APPLY:

I have applied for or will apply for federal or state medical assistance?

☐ Yes ☐ No-explain reason:

☐ Medicaid eligible, but not for date of service or for non-covered services

☐ I have health insurance, but not for date of service or the service was not covered or applied to deductible

☐ Deceased with no estate

☐ Religious Exemption (Federal Exemption for the Affordable Care Act)

PROVIDE ALL SUPPORTING DOCUMENTATION FOR THE ITEMS BELOW:

☐ Current Federal Tax Return	☐ Letter describing your financial situation
☐ Checking and Savings bank statements (include last 3 months)	☐ Pay Stubs (include last 2)

☐ Do you have health insurance? **Y** **N** If no, you will need to provide proof of Wisconsin Medical Assistance (Medicaid) approval or denial unless you qualify for a religious exemption. Questions can be directed to the contact at the bottom of the application.

Reviewed 12/20/2017

OTHER MONTHLY INCOME

Adjusted Gross Income: $	Rental Income: $	Short/Long Term Disability: $	Social Security/SSI: $
Pension: $	Workers Comp: $	Alimony/Child Support: $	Other: $
Veterans Benefits: $	Interest/Dividends $		

ASSETS:

Checking Balance: $	Savings Balance: $
Stocks/Bonds: $	Other IRA/CD/HSA/HRA: $
401K: $	

CERTIFICATION

I certify that the information listed in this application is true and correct. Any false information presented on this application may result in a declined financial assistance determination.

Patient/Responsible Party Signature:	Date:

Applications and supporting documentation can be dropped off at Vernon Memorial Hospital at the main lobby registration desk, or mailed to:

Vernon Memorial Healthcare-Patient Accounts

507 S. Main Street

Viroqua, WI 54665

Please call (608) 637-2101 with any questions.

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