Enclosed please find a Caring Hearts Financial Assistance Application. **Please complete the entire application and submit all requested supporting documentation to avoid denial of your application.**

Caring Hearts is a financial assistance program designed for patients who are unable to pay for medically necessary services provided by all divisions within ThedaCare. ThedaCare has established eligibility guidelines for our Caring Hearts Program based on financial need and is considered to be the last resort after all other payment sources have paid.

The Caring Hearts Program covers services which are deemed to be medically necessary as determined by your physician.

The Caring Hearts Program does not cover:

- Elective Services - cosmetic, bariatric, as well as other non-medically necessary services
- **Non ThedaCare providers –** examples include radiologists, pathologists, anesthesiologists, independent surgeons, and independent physicians. A complete list of covered and non-covered providers can be found in the document titled "List of Providers that are covered/not covered by Caring Hearts".
- Dates of Service that were paid directly to you by the insurance company.
- Dates of Service pending third party liability payment.

You may obtain a copy of the ThedaCare Caring Hearts Financial Assistance Policy or the list of covered and non-covered providers by:

1. Visiting our web site at www.thedacare.org/PaymentOptions
2. Contacting our Customer Support Department at 1-800-236-4102
3. Mailing a request in writing to: ThedaCare Billing PO Box 8003 Appleton, WI 54912
4. Stop by the registration desk in our admission areas

ThedaCare may continue collection efforts of unpaid balances if a complete application along with all requested supporting documentation is not returned within 30 days. A letter stating your acceptance or exclusion from the Caring Hearts Program will be sent after your completed application has been processed.

If you have any questions or need assistance in completing the application, please call our customer support department at 920-830-5900, or toll free at 800-236-4102.

Sincerely,

ThedaCare Customer Support Department

Caring Hearts Application

Date:___________________ Account Number:__________________________

Name of responsible party: ____Birth Date: _______________

Name of Spouse: ____ Birth Date: ________________
First Last

Address: _____________________________________City/State: ______________________Zip: ___________

Phone Number: Home: ________________________ Cell: ________________________

Marital Status (Please Circle): Married Single Widowed Separated Divorced Life Partner

List all dependents in your household:

Name	Date of Birth	Relationship to You	Dependent on your most recent Federal Tax Return?
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

Are there any open claims for workman's compensation, motor vehicle accidents, or third party liability that may pay on dates of service related to this request for financial assistance? __Yes __No
If yes, date of Incident: _____________________

Are you participating in a cost share program? __Yes __ No

Is there anyone in the household currently without health insurance? __Yes __ No
If yes, please list who: ____

Income: Please list all income below received monthly by all members of the household. This includes: employment, self-employment, unemployment, social security, disability, VA benefits, pension, retirement, monthly annuity payments, etc.

Recipient's Name	Source of Income	Start Date	Monthly Amount

If you have no source of income, how have you been supporting yourself?

____

____

Signature of person supporting you: _____________________ Print Name:__________________________

Relationship: ______________________ Can we discuss this application with the above? Y / N

Please list all open checking and savings account(s) for all household members below:

Account Owner	Type of Account	Bank Name	Estimated Balance

I certify that the above information is true and accurate to the best of my knowledge. Further, I will take action to apply for any assistance (Medicaid, Medicare, insurance, etc.), which may be applicable for payment of my hospital/physician charges, and I will take any action reasonably necessary to obtain such assistance. I will assign or pay to ThedaCare the amount recovered for charges. I authorize ThedaCare to verify any and all information presented in this application including but not limited to: employment verification and bank verification. I understand that any false or misleading information will void this application and exclude me from financial assistance. I understand that ThedaCare will scan and retain all financial assistance applications and financial documentation in accordance with its internal and external compliance requirements.

Date of Request: ___________________________

Applicant's Signature: ____

Required Financial Documentation – PLEASE READ CAREFULLY

Please read the scenarios below and proceed to the appropriate section on pages 3 and 4 based on your tax filing status. You only need to complete the **one section** that best fits your situation.
The financial documentation must be submitted with your application.

Are you required to file taxes by the Federal Government? **Please check one of the following:**

- ◻ If Yes and your financial situation has not changed since filing: Proceed to Section A
- ◻ If No: Proceed to Section B
- ◻ If Yes and self-employed: Proceed to Section C
- ◻ If Yes and your financial situation has changed since filing: Proceed to Section D

Section A: Required to File Taxes and Your Financial Situation Has Not Changed Since Filing

Please include the following information:

- ☐ For all bank accounts listed above, please include the full, detailed statement for the most recent month. Statements need to include financial institute name, account holder name, account number(s) and need to include all pages.
- ☐ Please submit a copy of your most recent Federal Tax Return. To request a copy of your taxes if needed, please call 1-800-829-1040.
- ☐ Completed and signed Caring Hearts Application.
- ☐ Written approval/denial response from Medical Assistance if any of the following apply:
  - -If you have children under the age of 18
  - -If you are currently pregnant
  - -If you have been determined disabled
  - -If you are over the age of 65
  - -If you are a Wisconsin immigrant with a medical emergency
  - -If you are childless adult within Federal Poverty Guidelines

Contact the Department of Health and Human Services in the county that you reside in or access their website at (https://access.wisconsin.gov/access/) for assistance.

Section B: Not Required to File Taxes

Please include the following information with your application:

- ☐ For all bank accounts listed above, please include the full, detailed statement for the most recent month. Statements need to include financial institute name, account holder name, account number(s) and need to include all pages.
- ☐ 2 most recent payroll statements or proof of income received
- ☐ Completed and signed Caring Hearts Application.
- ☐ Written approval/denial response from Medical Assistance if any of the following apply:
  - -If you have children under the age of 18
  - -If you are currently pregnant
  - -If you have been determined disabled
  - -If you are over the age of 65
  - -If you are a Wisconsin immigrant with a medical emergency
  - -If you are childless adult within Federal Poverty Guidelines

Contact the Department of Health and Human Services in the county that you reside in or access their website at (https://access.wisconsin.gov/access/) for assistance.

Section C: Self-Employed

Please include the following information with your application:

☐ Please submit a copy of your most recent Federal Tax Return. To request a copy of your taxes if needed, please call 1-800-829-1040.

☐ For all bank accounts listed above, please include the full, detailed statement for the most recent month. Statements need to include financial institute name, account holder name, account number(s) and need to include all pages.

☐ Completed and signed Caring Hearts Application.

☐ Written approval/denial response from Medical Assistance. Contact the Department of Health and Human Services in the county that you reside in or access their website at (https://access.wisconsin.gov/access/) for assistance.

Section D: Required to File Taxes and Your Financial Situation Has Changed Since Filing

Please include the following information with your application:

☐ Please submit a copy of your most recent Federal Tax Return. To request a copy of your taxes if needed, please call 1-800-829-1040.

☐ For all bank accounts listed above, please include the full, detailed statement for the most recent month. Statements need to include financial institute name, account holder name, account number(s) and need to include all pages.

☐ The most recent pay stubs from the last 60 days.

☐ Completed and signed Caring Hearts Application.

☐ Written approval/denial response from Medical Assistance if any of the following apply:
- -If you have children under the age of 18
- -If you are currently pregnant
- -If you have been determined disabled
- -If you are over the age of 65
- -If you are a Wisconsin immigrant with a medical emergency
- -If you are childless adult within Federal Poverty Guidelines

Contact the Department of Health and Human Services in the county that you reside in or access their website at (https://access.wisconsin.gov/access/) for assistance.

Financial Changes

Please describe any financial changes that have occurred since the completion of most recent Federal Tax Return. Please attach any additional documentation or verification of the financial changes noted below.

Describe Change:	Previous	Current
______________________________	$__________	$__________
______________________________	$__________	$__________
______________________________	$__________	$__________
______________________________	$__________	$__________
	$	$