COMMUNITY CARE PROGRAM

Thank you for your interest in the Osceola Medical Center Community Care program. Community Care is a financial assistance program that can assist you with the medical bills you have through Osceola Medical Center. Please refer to the information below while completing your application.

- Community Care will only assist with ***medically necessary*** services, which excludes elective services and prescription medications. Osceola Medical Center will determine if a service is medically necessary.
    - Examples of excluded services are, *but not limited to,* the following: IUD placement, colposcopy, nail ablation, lesion/wart removal, Chemotherapy, and endometrial aspirate.
    - Surgery services and diagnostic imaging such as MRI's and CT's will need to be pre-approved before scheduling.
    - **If you are unsure if a procedure or services will qualify for Community Care, please call the number below prior to your appointment.**

- It is important that you provide us with ***current*** insurance, income, and asset information, even if your situation has changed since you incurred your bills with Osceola Medical Center. Eligibility is based on your current household income and assets. This program is only available to those who are established patients at Osceola Medical Center and/or from the surrounding Osceola community.

REQUIRED ACTIONS: If you, or any of your dependents, currently have no medical coverage and fall within the income and asset guidelines for government health care programs (Medical Assistance, Badger Care), we need you to apply for and fully utilize any of those programs you may qualify for. If you are denied for those programs, please send copies of your current denials. Please note: THIS DOES NOT APPLY TO PATIENTS WHO CURRENTLY HAVE MEDICAL INSURANCE OR ARE COVERED BY MEDICARE PARTS A & B.

Wisconsin residents please visit **www.healthcare.gov** *or call* **1(800)318-2596**
Minnesota residents please visit **www.mn.sure.org** *or call* **1(855) 366-7873**

DEPENDANTS: If claiming any dependents age 18 or older, please send a copy of your most recent 1040 Federal Income Tax form showing that you still claim them as a dependent. Community Care benefits for dependent children 18 years & older is determined on a case by case basis.

Required forms and documentation (*INCLUDE ALL ADULTS IN HOUSEHOLD*)

- ☐ Completed and signed Community Care application
- ☐ Complete copy of your 1040 federal tax return from the previous tax year
- ☐ Copy of pay stubs from recent 4 week period OR Copy of Unemployment Benefit Award letter
- ☐ Copy of recent bank statement
- ☐ Copy of a medical assistance denial letter (As stated in the Required actions box above)
- ☐ *If applicable:* Copy of a recent Social Security or Pension check or your proof of benefits statement
- ☐ *If applicable:* All other forms of income & liquid assets must have official documentation from which we can easily determine your gross income.

If you need assistance with this application, please use the contact information below. Applications need to be returned within 30 days or your file may be closed. Applications lacking the required documentation will be returned to you.

Jenny – Financial Counselor (715) 294-5684 (Last names beginning A-K)
Laura – Financial Counselor (715) 294-5637 (Last names beginning L-Z)

Gina – Patient Advocate (715) 294-5648

OMC Osceola Medical Center

COMMUNITY CARE PROGAM
Financial Assistance Application

1. PATIENT/RESPONSIBLE PARTY

Account Number(s)			Home Phone Number
Name	Social Security Number		Date of Birth
Street Address	City	State	ZIP
Spouse's Name	Spouse's Social Security Number		Spouse's Date of Birth

2. MEDICAL INSURANCE

Do you currently have medical insurance? □Yes □No Does your Spouse? □Yes □No

Insurance Company			Do you currently have Medicaid or Badger Care? □Yes □No Does your Spouse? □Yes □No
Effective Date	Group Number	ID Number	Do you have Medicare? □Part A □Part B □None Does your Spouse? □Part A □Part B □None
Spouse's Insurance Company			Medicaid, Badger Care or Medicare Effective Date: Spouse's Effective Date:
Effective Date	Group Number	ID Number	

3. DEPENDANTS

Use an additional sheet if necessary. If claiming dependents over the age of 18, you must include a copy of your most recent 1040 Federal Income Tax form showing their dependent status.

Name	Date of Birth	Relationship	Current Medical Coverage
Name	Date of Birth	Relationship	Current Medical Coverage
Name	Date of Birth	Relationship	Current Medical Coverage
Name	Date of Birth	Relationship	Current Medical Coverage

4. EMPLOYMENT STATUS

Applicant □Employed □Self-Employed □Unemployed □Retired
Spouse □Employed □Self-Employed □Unemployed □Retired

5. MONTHLY INCOME

Please attach verification documentation for all income

Patient's Wages	*$*
Spouse's Wages	*$*
Self Employment	*$*
Public Assistance	*$*
Social Security	*$*
Other:	*$*
TOTAL	***$***

6. LIQUID ASSETS

Please attach a statement for each asset that you list

Does not include Personal Property (car, house, etc.) or Retirement Investments (401K, IRA)	
Savings Account(s)	**$**
Checking Account (s)	**$**
Stocks/Bonds	**$**
C.D.'s	**$**
Money Market Accounts	**$**
TOTAL	**$**

PLEASE READ AND SIGN BELOW

I acknowledge that the information on this application is true and correct to the best of my knowledge, and I hereby authorize Osceola Medical Center to release this information to any physician, clinic, affiliate, and/or other area hospital or clinic to which I am referred. I also acknowledge that I must enroll in and fully utilize and comply with (1) any Health Care Programs that I may qualify for, or (2) any medical insurance that may be available to me through an employer, and that failure to do so could result in denial of continuing financial assistance from Osceola Medical Center.

_____ _____
Applicant's Signature Date

_____ _____
Spouse's Signature Date

BEFORE RETURNING THIS APPLICATION: Please be sure that you have completed all fields, and that you have included all necessary documentation for income and asset verification as well as any health care program denials that may be required of you. **PLEASE REFER TO THE ATTACHED PAGES FOR ADDITIONAL INFORMATION REGARDING REQUIRED DOCUMENTATION.**
INCOMPLETE APPLICATIONS WILL BE RETURNED FOR COMPLETION.

Osceola Medical Center 2600 65th Ave, P.O. Box 218, Osceola, WI 54020 | **Phone**: 715-294-2111 | www.MyOMC.org
Scandia Clinic 21150 Ozark Ct. N. Suite 4, P.O. Box 218, Scandia MN, 55073 **| Toll Free:** 888-565-4662 | www.ScandiaClinic.com