

For Internal Business Purposes Only  
 Application given to patient by: Name \_\_\_\_\_ Site/Location \_\_\_\_\_ Department \_\_\_\_\_

### Helping Hand Assistance Application

Aurora Health Care-Helping Hand Program

P.O. Box 511156

New Berlin WI 53151-1156

*We are here to help! Please call us if you have any questions while filling out your application and gathering your documents. Call us at 1-800-326-2250*

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  
 Spouses \_\_\_\_\_

Address \_\_\_\_\_  
 First Middle Last e-mail 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

Name Age Name Age

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](http://www.irs.gov) and type "Order a transcript" in the search field.

### SOURCE OF INCOME FOR CURRENT YEAR

(If married, both required)

### YEAR-TO-DATE GROSS AMOUNT

\_\_\_\_\_ \$ \_\_\_\_\_ (You must **attach** year-to-date proof of income for each source)

\_\_\_\_\_ \$ \_\_\_\_\_ (You must **attach** year-to-date proof of income for each source)

\_\_\_\_\_ \$ \_\_\_\_\_ (You must **attach** year-to-date proof of income for each source)

\_\_\_\_\_ \$ \_\_\_\_\_ (You must **attach** year-to-date proof of income for each source)

**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 Health Care 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

\_\_\_\_\_  
Signature of Notary

SEAL

My Commission Expires \_\_\_\_\_