5409 Everybody's Road, P.O. Box 396, Crandon, WI 54520

715/478-4361

Name of Head of Household				Place of Employment						
Street City			State Zip		Zip	Phone				
Health Insura	nce Plan			Social Security Number						
Please List S	pouse and all D	ependents 1	Under Age 18 o	r in hou	seholo	1				
	Name		Date of Birth	Name				Date of Birth		
Self				Dependent						
Spouse				Dependent						
Dependent				Dependent						
Dependent					dent					
	A 1 II -	h.ald I								
Source	Annual Ho	usenoia inc	come		0.16		Other	er Total		
	galarias tima at				Self		Spouse	Other	+	lotai
Gross wages, salaries, tips, etc.									+	
Social security, pension, annuity, and veteran's benefits									+	
Alimony, child support, military family allotments									+	
Income from business self-employment, and dependents									+	
Unemployment, worker's compensation, strike benefits									+	
Rent, interest, dividend, and other income								_		
Total Income										
Verification Checklist (atta				ach copies)					Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card, or other										
Income: Prior year tax return, three most recent pay stubs, or other										
Insurance: In	surance card(s)									
BadgerCare Plus: Application made or evidence of rejection (Effective until)										
I certify that the information shown above is correct and understand that verification is required for approval.										
Print Name				Signature/Date						
Relationship	to patient:									

March 11, 2009

FOREST COUNTY POTAWATOMI HEALTH AND WELLNESS CENTER **FAMILY ASSISTANCE PLAN**

Policy		
Foncy		

It is the Forest County Potawatomi Health and Wellness Center ("FCPHWC") policy to provide medically necessary services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. It is intended for patients who have no other insurance and who do not qualify for BadgerCare Plus or Medicare. A sliding fee schedule is used to calculate the amount of discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for six months, after which the family must reapply. If payment is not made within the normal time allowed in our collection policies, the benefit of the reduced amount will be forfeited and the entire original charges will be your responsibility to pay the clinic. You will be notified of this through our regular billing procedures. A \$10.00 co-pay will be required of patients receiving any service except Dental and Optical Services. The Dental & Optical Service co-pay will be \$25.00. All co-pays will be expected prior to services being rendered. *Any Self-Pay policies within each department for individuals other than the 100% discount clients will be applicable for your remaining balance due

Discount Application	

An application must be submitted to and approved by the FCPHWC Health Funding Specialist before a discount will be granted. The initial application must include at least the following information: home address; n

	ome, insurance coverage or proof from employer that insurance is not obtainable through ent. All applicants will be required to apply for alternative resources and provide a writter in approval.
Covered and Exclude	ed Services
Medical:	The discount is applied to all in-office services.
Dental:	The discount is applied to approved in-office preventative and restorative services Excluded services include: dentures; inlays; crowns; bridges and cosmetic services.
Pharmacy	Excluded Service
Lab & X-ray:	The discount is applied to in-office laboratory and x-ray services. Reference laboratory tests and consulting radiology interpretations are excluded. Recipient will be billed for these costs.
Behavioral Health:	The discount is applied to in-office Mental Health and AODA services.
Therapy Services:	The discount is applied to in-office Physical Therapy and Speech Therapy.
Optical Services:	The discount is applied to evaluations and treatment only. Glasses and contact lenses are excluded.
Referred Care:	The discount is not applied to care provided out-of-office. Examples of out-of-office exclusions include: emergency room visits; hospital care; specialty care; infertility counseling; diagnostic tests such as CAT scans and MRIs, and any other care not provided at the FCPHWC.
I, the undersigned ha	eve read and understand the program guidelines.

Date:



Forest County Potawatomi Health and Wellness Center PO Box 396 Crandon, WI 54520

Phone: 715-478-4300 Fax: 715-478-4496 Medical Records 715-478-4323

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient:						
Last Name	First Na	me, MI		Date of Birth	\$	SS#
Street Address			City	State		Zip
Authorize Records	to be releas	ed From:		Information Records to	o be Rel	eased To:
POTAWATOMI I	HEALTH &	WELLNESS				
Name PO BOX 396			_	Name		
Street Address CRANDON,	WI	54520	<u></u>	Street Address		
City	State	Zip		City	State	Zip
Information to be a NOTE: Release of Medical history Prescriptions Hospital reports X-ray reports Other:	of psychother y, examination	capy notes rec	quires a La Tr Er	oply) a separate authorization. aboratory reports reatments or tests mergency reports ental records	C	perative reports onsultations ental x-rays
Verbal InformaAssessment ReSubstance Abu	esults	t Records		ychiatric Evaluations ychological Evaluations		reatment Plan ischarge Summary
	nsurance Cla ermination ERNATIVE vers Licens	RESOURO e, State ID	E wi	Further Medical Care forker's Comp Claim th copies of Birth (al Security Card an <u>X</u> WWWP re	Le Certificand/or (1	HCF 10154) form

Authorization Conditions:

We will not condition treatment, payment or enrollment or eligibility for benefits on whether this Authorization is signed. However, we require authorization prior to providing research-related

March 11, 2009

____Deceased

Next of kin if deceased

for disclosure to a third party.
Authorization Expiration: This Authorization expires on (date): If no expiration date is specified, this Authorization will remain in effect for one year from the date it was signed. I request that this Authorization be effective for medical records generated up to the date of expiration unless specified below:
Revocation: I understand I may revoke this authorization at any time by providing a written revocation to FCPHWC, except to the extent that FCPHWC has used or disclosed information in reliance on this Authorization or it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy.
I understand that there is potential for information disclosed as a result of this Authorization to be redisclosed by the person receiving the information and, therefore, it may no longer be protected.
Signature (if signed by person other than patient, state relationship below) Date

treatment or if the treatment provided is solely for the purpose of creating protected health information

We can only honor a request if this form is filled out completely and contains an original signature. A copy of any Authorization requested by FCPHWC will be provided to you.

_Minor ____Incompetent _Parent or legal guardian

Patient is:

Legal Authority: