

Wellness Center of Door County, Inc.  
312 N. 5<sup>th</sup> Avenue, PO Box 85  
Sturgeon Bay, WI 54235  
(920) 746-9444

### **The Sue Baldwin Fund**

Purpose: The Sue Baldwin Fund has been established to support the early detection of breast cancer by providing financial support to men and women needing breast cancer screening, who might otherwise not seek the appropriate services due to financial constraints.

Services typically eligible for financial support include mammography, ultrasound, breast biopsy, and/or surgical consultation.

#### Criteria for Applicants:

- Man or woman needing breast cancer screening services and/or diagnostic work-up and evaluation;
- Is uninsured or underinsured; or
- Has an insurance deductible greater than \$1,000.00, and
- **Is a resident of Door County.**

#### Process:

1. Referral forms for diagnostic services shall have "Wellness Center of Door County-The Sue Baldwin Fund" clearly identified/marked at the top of the form.
2. Patient will submit an application, a SASE and a \$25 fee to the Wellness Center for financial support through this program. Information provided will include income (paycheck stubs for two prior months) and documentation of insurance provider's coverage, or lack thereof, for the needed services, when applicable.
3. If patient is eligible for financial support through the service provider (e.g., Community Care Program of Door County Memorial Hospital), that approval process must be completed before submitting bills to WCDC for services received. A copy of the approval notification or declination needs to be submitted with the bill(s).
4. Patient will submit the service provider's bill to the Wellness Center, along with a SASE and the approval notification from the service provider when applicable.
5. The Wellness Center's sliding scale (see attached) will be used to determine the percent of the balance that will be paid, and a letter of notification will be sent to the patient.
6. Patients may appeal the decision by submitting a letter of request and additional documentation of need. Appeals will be reviewed by an ad hoc subcommittee of the Wellness Center Board of Directors.

7. Payment will be made directly to the service provider.
8. Application must be renewed annually if service needs continue beyond one calendar year.
9. Disbursement of funds is contingent on availability. Determination of financial assistance will be as follows:

| <u>% of federal poverty level</u> | <u>% of service bills paid</u> |
|-----------------------------------|--------------------------------|
| Below 150%                        | 100 %                          |
| 150 - 200%                        | 90 %                           |
| 200 - 250%                        | 70 %                           |
| 250 - 300%                        | 50 %                           |
| 300 - 350%                        | 30 %                           |
| 350 - 400%                        | 10 %                           |

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STURGEON BAY, WI 54235

THE SUE BALDWIN FUND APPLICATION FOR ASSISTANCE  
*PLEASE PRINT*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City: \_\_\_\_\_, WI ZIP: \_\_\_\_\_

County: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Health Insurance: \_\_\_ None Company Name: \_\_\_\_\_

(Please present your card) How much is your deductible that must be met? \$ \_\_\_\_\_

Number of DEPENDENT children under the age of 19 that live in your home: \_\_\_\_\_

Married: \_\_\_ No \_\_\_ Yes ---Spouse's gross (before taxes) MONTHLY income: \_\_\_\_\_

YOUR CURRENT EMPLOYMENT AT:

\_\_\_\_\_  
Business Name Phone Number

\_\_\_\_\_  
Business Name Phone Number

I certify that the information I am providing is accurate to the best of my ability. I am attaching the following with this application:

- Self-Addressed Stamped Envelope
- Copies of the previous 2 months paystubs from all of my jobs (if married- include spouse's)
- \$25 application fee made payable to the Wellness Center of Door County
- Letter of Community Care Program acceptance or declination from the service provider (hospital, diagnostic imaging or radiology service).

I also understand that once I receive notification I am to submit the hospital, surgeon consult and/or radiology bill(s) for my diagnostic tests and/or procedure. Assistance with payment will be limited to these services, will be based on available funding following verification of my/our income and I will be responsible for the remaining balance of any bill(s).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Office Use Only: FPL \_\_\_\_\_ Approved @ \_\_\_\_\_% Declined \_\_\_\_\_