



RIVERVIEW HEALTH

Exceptional People. Exceptional Care.

BO58

Effective January 2020

INDIVIDUAL WRITTEN NOTICE TO ALL PATIENTS AVAILABILITY OF COMMUNITY CARE

As a commitment to the community and people of the surrounding area, RiverView Health will make available a reasonable amount of uncompensated services to individuals based on established income guidelines.

RiverView Health's community care services do not include RiverView Recovery Center, prescriptions, Home Healthcare, or RiverView Care Center.

Patient eligibility for community care is determined by measuring annual gross income and family size against the income guidelines. The income guidelines are based 150% on Federal Poverty Level income guidelines published by the Department of Health and Human Services. The guidelines established by the Federal government have been increased by 50%. Source: [FR Doc. 2020-00736 Filed 1-16-20; 8:45 am] Scheduled Publication Date: 01/16/2020 Agency: Secretary of Health and Human Services Department; Document Number: 2020-00736

The current income requirements for 150% uncompensated services are listed below.

Size of Family	Income Guidelines
1	\$ 19,140.00
2	\$ 25,860.00
3	\$ 32,580.00
4	\$ 39,300.00
5	\$ 46,020.00
6	\$ 52,740.00
7	\$ 59,460.00
8	\$ 66,180.00
9	\$ 70,660.00
10	\$ 75,140.00
For Each Additional Family Member Add	\$ 4,480.00

If you think you may be eligible for community care and wish to request it, please complete the application form and return it to RiverView's Patient Financial Service Department. If questions, call Jessica Holzer (218) 281-9283 or email Jholzer@riverviewhealth.org. If your income is above the income guidelines, you may be eligible for uncompensated discounts.

RiverView Health
323 S Minnesota St *Crookston MN 56716-1600
1-800-743-6551 or 218-281-9283
FAX: 218-281-9224



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APPLICATION FOR COMMUNITY CARE

REQUESTS WILL BE REVIEWED AND A RESPONSE WILL BE GIVEN WITHIN 30 WORKING DAYS.

DATE: ____/____/____

NAME: _____ DOB ____/____/____
(FIRST) (LAST)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

TELEPHONE: _____
(HOME) (WORK) (MOBILE)

SPOUSE: _____ DOB ____/____/____
(FIRST) (LAST)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

TELEPHONE: _____
(HOME) (WORK) (MOBILE)

MARITAL STATUS: ___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED

LIST ALL DEPENDENTS LIVING IN YOUR HOUSEHOLD THAT ARE CLAIMED ON PREVIOUS YEAR TAX STATEMENT (ATTACH ADDITIONAL SHEET IF NEEDED)

	<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MI</u>	<u>DATE OF BIRTH</u>	<u>RELATIONSHIP TO APPLICANT</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

PROOF OF INCOME – ATTACH ONE OR ALL

- COPY OF MOST RECENTLY FILED 1040 OR 1040-EZ, INCLUDING SCHEDULES
- IF EMPLOYED: PAY STUBS FOR THE MOST RECENT 90 DAYS
- IF SELF EMPLOYED: BANK STATEMENTS FOR THE MOST RECENT 90 DAYS
- IF DISABLED: SOCIAL SECURITY INCOME PAYMENT STUBS FOR THE MOST RECENT 90 DAYS

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RIVERVIEW HEALTH FINANCIAL DISCLOSURE

INCOME: REPRESENTS TOTAL CASH RECEIPTS FROM ALL SOURCES BEFORE TAXES

SELF MONTHLY GROSS

SPOUSE MONTHLY GROSS

GROSS INCOME	\$	GROSS INCOME	\$
SOCIAL SECURITY/SSI/SSDI	\$	SOCIAL SECURITY/SSI/SSDI	\$
PUBLIC ASSISTANCE	\$	PUBLIC ASSISTANCE	\$
RENTAL INCOME	\$	RENTAL INCOME	\$
RETIREMENT/PENSION	\$	RETIREMENT/PENSION	\$
VETERANS BENEFIT	\$	VETERANS BENEFIT	\$
UNEMPLOYMENT/WORK COMP FROM: TO:	\$	UNEMPLOYMENT/WORK COMP FROM: TO:	\$
CHILD SUPPORT FROM: TO:	\$	CHILD SUPPORT FROM: TO:	\$
OTHER PLEASE IDENTIFY:	\$	OTHER PLEASE IDENTIFY:	\$
TOTAL	\$	TOTAL	\$
COMBINED MONTHLY GROSS INCOME \$			

I understand the information I submit is subject to verification by RiverView Health and subject to review by Federal and/or State agencies and other as required. By signing below I certify the above information is true and correct.

I certify that everything I have stated in this disclosure and on any attachments is correct. I understand the information provided on this Financial Disclosure Form is for the purpose of determining my/our ability to pay our debt to RiverView Health.

Signature _____
Date

Spouse Signature _____
Date

DO NOT COMPLETE – BUSINESS OFFICE USE ONLY

Document received on: _____ Received by: _____

Guarantor Account: _____ In the amount of: _____

Comments: _____

Approved: _____ Denied: _____ Signed: _____ Date: _____