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: 218-470-2020

RIVERVIEW HEALTH
Exceptional People. Exceptional Care.

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)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	RELATIONSHIP TO APPLICANT
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

RiverView Health
323 S Minnesota St *Crookston MN 56716-1600
1-800-743-6551 or 218-281-9283
FAX: 218-470-2020

RIVERVIEW HEALTH FINANCIAL DISCLOSURE

INCOME: REPRESENTS TOTAL CASH RECIEPTS 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:** _____

RiverView Health
323 S Minnesota St *Crookston MN 56716-1600
1-800-743-6551 or 218-281-9283
FAX: 218-470-2020