

APPLICATION FOR CHARITY CARE**PLEASE DO NOT SEND ORIGINAL DOCUMENTS, AS THEY WILL NOT BE RETURNED TO YOU. PHOTOCOPIES ARE ACCEPTABLE.**

1. General. All applicants, regardless of race, color, creed, religion, national origin, disability, sex, age, or status in regards to public assistance will be considered.
2. Application. Application for Charity Care must be submitted to the Program Coordinator along with the following:
 - a. Copies of federal income tax return and W2 forms (for the most recent preceding tax year) for the applicant and all adults included on that tax statement. If a person required to submit a return did not file one, or if income sources have changed since the return was filed, then that person shall submit evidence showing his/her income for the 12 months immediately preceding application, less withholding and self-employment taxes. **Proof of income must be attached.**
3. Services. All services provided by Ridgeview Hospital and Clinics are eligible for the Charity Care Program, except for the following:
 - a. Cosmetic services, tubal reversals, and services provided at the Spa in the Excelsior clinic are not covered.
 - b. Elective surgical procedures are not covered unless applicant can demonstrate to the Program Coordinator that an exceptional cause exists for coverage.
 - c. Insurance office visit co-payments.
 - d. Hearing aids
4. Eligibility. To apply for the Charity Care, an applicant must return the completed application with a copy of their entire Federal Income Tax Return for the preceding tax year. The level of Charity Care will be determined by the Program Coordinator. For questions, please call Ridgeview Medical Center 952-442-2191 ext. 6573.

Notice to Uninsured Applicants. In addition to the above financial information, all uninsured patients who appear to be eligible for Medical Assistance, General Assistance Medical Care, and/or Minnesota Care will be asked to provide valid denials or determinations from those programs. If you have not yet done so, please contact your local county offices to apply for those programs. Please allow 30 days for us to send you a written approval or denial by mail.
5. Payments from Applicant. When an applicant is approved for financial assistance through the Charity Care Program, payment arrangements must be made and agreed upon by applicant and Ridgeview Medical Center for any remaining balances. Failure to fulfill the payment arrangements will result in the discount being reinstated and the entire balance becoming due and payable at once.



500 South Maple Street • Waconia, MN 55387
 (952) 442-2191 or 1-800-967-4620

Patients Name: _____
 Date Application Sent _____

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- 6. Payments from Collateral Sources. All available health insurance proceeds shall be paid directly to Ridgeview Medical Center. If there is liability insurance, other private insurance, a lawsuit, or reimbursement available from any other source, it will be paid directly to Ridgeview Medical Center or arrangements will be made for direct payment, before an applicant is eligible for Charity Care and/or Matching Payment Plan.
- 7. Right to Amend and Repeal Plan. Ridgeview Medical Center reserves the right to modify or repeal the Charity Care and/or Matching Payment Plan, at any time, as it deems necessary.
- 8. Completed Application. This application must be received in the appropriate Business Office within 30 days of "Date Application Sent" date to qualify for consideration of Ridgeview's Charity Care and/or matching Payment Plan.

PATIENT'S HOUSEHOLD DEMOGRAPHIC AND FINANCIAL INFORMATION

Charity Care Guidelines:

To apply for Charity Care, an applicant and all adults(18 years and older) included on that tax statement residing with him/her must show that their federal adjusted gross incomes, when combined, fall within the Guidelines set forth below. For purposes of the Guidelines, "Family Size" means the number of persons residing in applicant's household for whom an exemption could be claimed on the federal income tax returns. Assets and liabilities will also be considered in the Charity Care determination.

CHARITABLE SERVICE INCOME GUIDELINES

Family Size	Federal Adjusted Gross Income *	% of Bill Forgiven	\$1500 Over Adj Gross Income % of bill Forgiven	\$3000 Over Adj Gross Income % of bill Forgiven	Limit on Forgiven Dollars per year
1	\$27,225.00	100%	75%	50%	\$300
2	\$36,775.00	100%	75%	50%	\$400
3	\$46,325.00	100%	75%	50%	\$550
4	\$55,875.00	100%	75%	50%	\$750
5	\$65,425.00	100%	75%	50%	\$1000
6	\$74,975.00	100%	75%	50%	\$1350
7	\$84,525.00	100%	75%	50%	\$1825
8	\$94,075.00	100%	75%	50%	\$2450

(For each additional person add \$9,550.00)

** 250% of Federal Poverty Guidelines for year 2011/2012 per Fed. Reg. **

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 RIDGEVIEW HOSPITAL ACCOUNT _____
 RIDGEVIEW CLINICS ACCOUNT _____

PATIENT'S HOUSEHOLD DEMOGRAPHIC AND FINANCIAL INFORMATION

I request the hospital to determine if I am eligible for Ridgeview Charity Care financial assistance in clearing my hospital bill based upon household income and other financial information. I understand that I am required to give certain financial information. I also understand that the hospital or its agents may check the information for accuracy. I understand that filling out this form does not guarantee that I will receive this financial help. If I am not eligible for financial assistance, I will still be responsible for my hospital bill.

Please Print

Name (head of household):			
	First	Middle	Last

Patient's Name:		Date of Birth:	
Home Mailing Address:			
City:		State	Zip:
Telephone # (Daytime):		Telephone # (Evening):	
Names and date of birth of Family Members living with you for which you are financially responsible and can claim on your income tax:			
Name	Date of Birth	Name	Date of Birth

List Income for Household from:	Annual Income
Wages - self	\$
- spouse	\$
- Other family members	\$
Farm or self-employment (less depreciation)	\$
Public assistance	\$
Social Security	\$
Unemployment Compensation	\$
Strike Benefits	\$
Alimony	\$
Child Support	\$
Military Income	\$
Pensions	\$
Income from dividends, interest, rent	\$
All Other Income	\$
Food Assistance	\$
Fuel Assistance	\$

Office Use Only	
DOB	
DOS	
INS	
Service	
Imaging	
Clinic	

TOTAL HOUSEHOLD YEARLY INCOME	\$
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PATIENT'S HOUSEHOLD DEMOGRAPHIC AND FINANCIAL INFORMATION

List all Employers Contributing to Household Income

Employer's Name:	Employer's Phone: ()
Employer's Address:	
Employer's Name:	Employer's Phone: ()
Employer's Address:	

ASSETS [A]

Cash

Name of Bank/Financial Institution	Acct. Type	Current Balance
	<input type="checkbox"/> Savings/Money Market	\$
	<input type="checkbox"/> Checking	\$
	<input type="checkbox"/> Checking	\$
	<input type="checkbox"/> Savings/Money Market	\$
	<input type="checkbox"/> Checking	\$
	<input type="checkbox"/> Savings	\$
	TOTAL CASH	\$

Investments

Stock/Bond/Mutual Fund/etc.	Shares	Value
Certificate of Deposits (CD)		\$
IRA		\$
Tax Deferred Annuities and Pension		Value
		\$
		\$
TOTAL INVESTMENTS		\$

Real Estate

Estimated Market Value of Principal Residence (ATTACH A COPY OF YOUR PROPERTY TAX STATEMENT)	\$
Other Real Estate (List Address or Location and Estimated Market Value)	\$
	\$
	\$
TOTAL REAL ESTATE	\$

Other Property (List all Autos, Trucks, Boats, Snowmobiles, Other Vehicles Titled to you/spouse)

Vehicle Type	Make/Year	Value
		\$
		\$
		\$
	TOTAL OTHER	\$

All Other Assets (including if you are a beneficiary of an estate settlement in process)

	\$
	\$
	\$
TOTAL OTHER	\$
TOTAL ASSETS	\$



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PATIENT'S HOUSEHOLD DEMOGRAPHIC AND FINANCIAL INFORMATION

LIABILITIES [B]

Loans (List all Mortgages and other Loans)

Name of Bank/Financial Institution	Description of Item Financed	Loan Balance
		\$
		\$
		\$
	TOTAL LOANS	\$

Credit Cards

Name of Card Company	Current Balance
	\$
	\$
	\$
	\$
	\$
	TOTAL BALANCE

Property Taxes Payable	\$
Rent	\$

Other Liabilities (Please Describe)

	\$
	\$
	\$
*** ATTACH SHEET OF ADDITIONAL LIABILITIES ***	\$
	TOTAL OTHER LIABILITIES

TOTAL LIABILITIES	\$
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(B)

NETWORTH (A) Assets minus (B) Liabilities	\$
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The information given above is true to the best of my knowledge. I have provided income verification with copies of my most recent Federal and State Income Tax Return and employer earnings W2 forms for applicant and all adults(18 years and older) included on that tax statement residing at this household address. I am aware that any misstated, missing, or false information can retroactively revoke my charity care allowance. It is also understood that by signing this form I am allowing Ridgeview Medical Center to verify all items listed.

X _____ | _____
 Signature of Applicant/Account Guarantor Date

Submit completed/Signed Form to:
Ridgeview Medical Center
Business Office
500 South Maple Street
Waconia, MN 55387

