Ridgeview MEDICAL CENTER

Acct: _____

Application for Community Care (Financial Assistance)

1. **General:** Ridgeview Medical Center's community care program is not an insurance, and is financial assistance for your Ridgeview Medical Center's bills. 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 community care must be submitted to the Program Coordinator along with the following:
   a. Please use the list below as a checklist when completing the application
      - ☐Application must be fully completed – **All boxes must be filled in**
      - ☐The information of the application has to match the supporting documentation exactly!
      - ☐Legible photocopy of most recent federal tax return with schedules
        Copies of past returns can be obtained from IRS at 800-829-1040
      - ☐Legible photocopy of all income from another source
      - ☐Legible photocopy of all proof of liquid assets
      - ☐Legible photocopy of Medical Assistance/Minnesota Care denial letter

   Note: If you are living with a significant other and you share a minor child together, we will consider your income as a family income. Please list the significant other and the child on the application, and provide all supporting financial documentation.
3. **Services:** Emergency or medically necessary treatment services provided by Ridgeview Medical Center and Clinics are eligible for the community care program including the following Ridgeview entities: Ridgeview Home Care Services, Ridgeview Sibley Medical Center and clinics. Services not deemed medically necessary or not of an emergent nature are not eligible for the community care benefit. Examples include: cosmetic services, tubal reversals, semen analysis, hearing aids, and elective surgical procedures.
4. **Eligibility:** To apply for community care, an applicant must return the completed application with a copy of their Federal income Tax Return for the most recent year. The level of community care will be determined by the Program Coordinator or designee. For questions, please contact Patient Financial Services at 952-442-8054.

   Note to Uninsured Applicants: Eligibility for all other insurance and third party payment options must be determined, including Medical Assistance and/or Minnesota Care prior to qualifying for community care benefits. Your Medical Assistance/Minnesota Care denial must be included for all applicants. Without this paperwork, we will be unable to process your application.
5. **Payment from Applicant:** When an application is approved for partial community care benefits, payment arrangements must be made and agreed upon by applicant and Ridgeview Medical Center for any remaining balance. In addition, any payments received prior to the approval of community care will not be refunded.
6. **Payments from Collateral Sources:** All available health insurance proceeds shall be paid directly to Ridgeview Medical Center. If there is a 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 community care benefits.
7. **Right to Amend and Repeal:** Ridgeview Medical Center reserves the right to modify or repeal the community care program at any time, as it deems necessary.
8. **Completed Applications:** The community care application and all supporting documents can be confidentially faxed to 952-442-8052 or mailed to:

   Ridgeview Medical Center
   Attn: PFS – Community Care
   500 South Maple Street
   Waconia, MN 55387

   The community care application and financial assistance policy can be printed from our website at www.ridgeviewmedical.org or you can obtain a copy by calling Patient Financial Services Monday through Friday 8am to 4:30pm at 952-442-8054. The application is available in English and Spanish.

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Community Care Application

Applicant Information

Name:		Date of birth:	
Address:	City:	State:	ZIP:
Primary Phone:	Marital Status:		
Significant other/Spouse Name:		Date of birth:	

Dependents claimed on your Federal taxes

Name:	Date of birth:	Relationship:

Applicant Employment information

Are you employed? ☐ No ☐ Yes - Complete below
Employer's Name:
Hourly wage/salary (include tips):
Employer's Name:
Hourly wage/salary (include tips):

Spouse/Significant other Employment information

Are you employed? ☐ No ☐ Yes - Complete below
Employer's Name:
Hourly wage/salary (include tips):
Employer's Name:
Hourly wage/salary (include tips):

Income from another Source

Do you or your significant other receive income from a source other than work? ☐ No ☐ Yes – Complete Below

Income Includes: Retirement/Pension, Interests/Dividends, Annuities, Unemployment, Rental Income, VA Benefits, Trusts, Social Security, Spousal Support, Child Support, Farm Income, Military Income, Wages earned by Dependents, or any other income.

Recipient Name:	Type of Income:	Annual Amount Received:

Bank Information/Liquid Assets

Do you have any liquid assets? ☐ No ☐ Yes – Complete below

Liquid assets include cash property that can be easily converted to cash such as savings and checking accounts, stocks, bonds, certificate of deposit, annuities, and money market accounts.

Type of Asset:	Name of Financial Institution:	Estimated Value:

Household Expenses (Monthly)

Mortgage/Rent $	Utilities (Gas/Electric) $	Medical Debt $

Special Circumstances (include additional pages if needed)

Please tell us of your special circumstances:

Acknowledgement and Sign

I acknowledge that the information of this application is true and correct to the best of my knowledge. I am aware that any misstated, misleading, missing, or false information can retroactively revoke my Community Care allowance. It is also understood that by signing this form I am allowing Ridgeview Medical Center to verify all items listed.

Signature of Applicant:	Date:

For Internal Use

Application has been: ☐ APPROVED FULL ☐ APPROVED PARTIAL _____% ☐ DENIED

Reason for Denial: ☐ Requested documents not received ☐ Did not apply for Medical Assistance ☐ Income Exceeds Guidelines ☐Other, explain_____

Reviewer Notes:	Amt Approved $
Director Approval:	Date: