Ridgeview
LE SUEUR MEDICAL CENTER

FOR RLMC RECORDS ONLY:
Date Received: _____
Most Recent Tax Form Recd: _____
Most Recent Pay Stub Recd: _____

FINANCIAL ASSISTANCE APPLICATION

If you need help filling out this application, or have other questions, please call our office.
We can help you!

Did you know that Ridgeview Le Sueur Medical Center (RLMC) has a financial assistance program that may help you with your medical bills? You may be eligible to have your bills reduced if your income falls between the guidelines listed below:

Household Size	100% Discount If Income is less than:	75% Discount If Income is less than:	50% Discount If Income is less than:
1	$23,760	$29,700	$35,640
2	$32,040	$40,050	$48,060
3	$40,320	$50,400	$60,480
4	$48,600	$60,750	$72,900
5	$56,880	$71,100	$85,320
6	$65,160	$81,450	$97,740

For families/households with more than 6 persons, add $4,180 for each additional household member

In order to qualify for Financial Assistance you must:

- Cooperate with your Workers Compensation, auto or any other insurance carrier.
- Have a determination of any Medical Assistance disability claim.
- Have received medically necessary, eligible medical services delivered through RLMC that are covered under our program. Please contact us for a list of covered services.
- Apply for Medical Assistance and other forms of public/private assistance depending on applicable eligibility guidelines.

Be sure you complete the whole application:

- Answer all questions on the application
- Attach copies of the forms needed
- Sign and date the application

Mail or fax this application and the requested copies to the address below:

Ridgeview Le Sueur Medical Center
Attn: Finance Dept
621 South Fourth Street
Le Sueur, MN 56058

Call: 507-665-8699
Fax: 507-665-2191

Please contact us if you have any questions about your eligibility for this program.

Please return the application and copies back to us within 30 days.

We may be able to assist you with other programs if you are not eligible for our Financial Assistance Program.

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Your Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Home No.: _____ Cell No.: _____

(Office Use only)
Account #_____

Do you own or rent at this address? ☐ I own. ☐ I rent. ☐ I don't own or rent.

If you don't own or rent your home, please explain where you live:

_____

Please list the people who live with you. (List only household members that you would claim on your taxes if you filed.)

First Name & Last name	Date of Birth	Relationship to you	Does this person have Medical Assistance? Yes	No	Pending

Check the box if your household has: (for **all** household members)		And please send copies of most recent:	Monthly Amount
	Employment wages/income	Paystubs & last year's Federal tax form 1040	$
	Tribal or Per Capita income	Statement or award letter	$
	Self-Employment / Farm Income / Rental income	Last year's Federal tax form 1040 & schedule C, F and/or E	$
	SSI / SSDI / RSDI income	Most recent bank statement or award letter	$
	Public Assistance (such as - food stamps, TANF, MFIP)	Award letter or statement from county	$
	Unemployment / WorkComp Benefit	Pay history printout or benefit letter	$
	Spousal / Child Support Income	Most recent pay history or bank statement	$
	Pension / Retirement / VA benefit	Most recent bank statement or award letter	$
	Annuity / Dividend / Interest Income	Most recent statement from bank	$
	Checking Accounts / Savings Accounts / Money Market Savings / CDs / H.S.A, H.R.A, Flex Savings Accounts	2 most recent complete statements for <u>each</u> account	$
	No income - In next space, explain how you support yourself (how do you deal with daily expenses like food, bills & housing?) →		**$0**

CHECK HERE IF YOU DID NOT FILE FEDERAL TAXES LAST YEAR → ☐

Please check the box if you have:		Total Estimated Value:
	Other property owned (besides your primary home – like land, cabins, timeshares, etc)	$
	Recreational vehicles (RVs, motorcycles, ATVs, boats, snowmobiles, etc)	$
	Retirement & Investment accts (IRAs, 401Ks, Stocks, Bonds, life insurance, trusts, etc)	$

We may request more documentation from the information above to complete the review of your application.

I/we hereby request that RLMC make a determination of my eligibility for the Financial Assistance Program. I acknowledge that the information provided in this application is true and correct. I understand that the information that I submit will be subject to verification by RLMC, and if this is determined to be false, it will result in a denial of the Financial Assistance Program. Failure to fully complete this application and provide supporting documents will result in denial of the application.

Applicant's Signature_____ Date _____

Thank you for completing this application! Your application is good for 6 months from the date we receive it.