



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.**



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

<input type="checkbox"/>	Employment wages/income	Paystubs & last year's Federal tax form 1040	\$
<input type="checkbox"/>	Tribal or Per Capita income	Statement or award letter	\$
<input type="checkbox"/>	Self-Employment / Farm Income / Rental income	Last year's Federal tax form 1040 & schedule C, F and/or E	\$
<input type="checkbox"/>	SSI / SSDI / RSDI income	Most recent bank statement or award letter	\$
<input type="checkbox"/>	Public Assistance (such as - food stamps, TANF, MFIP)	Award letter or statement from county	\$
<input type="checkbox"/>	Unemployment / WorkComp Benefit	Pay history printout or benefit letter	\$
<input type="checkbox"/>	Spousal / Child Support Income	Most recent pay history or bank statement	\$
<input type="checkbox"/>	Pension / Retirement / VA benefit	Most recent bank statement or award letter	\$
<input type="checkbox"/>	Annuity / Dividend / Interest Income	Most recent statement from bank	\$
<input type="checkbox"/>	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	\$
<input type="checkbox"/>	<b>No income</b> - 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:

<input type="checkbox"/>	Other property owned (besides your primary home - like land, cabins, timeshares, etc)	\$
<input type="checkbox"/>	Recreational vehicles (RVs, motorcycles, ATVs, boats, snowmobiles, etc)	\$
<input type="checkbox"/>	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.