The Richland Hospital, Inc.

Community Care Program Application

APPLICANT INFORMATION

Applicant's Name _____ Date of Birth _____

Spouse's Name _____ Date of Birth _____

Address _____

Telephone _____

Dependents (Must be eligible as a dependent on applicant's income tax return)

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

INCOME – Income for applicant (and spouse if applicable); (two or three) most recent pay stubs, unemployment insurance payment stubs, or sufficient information on how patients are currently supporting themselves.

Source of Income	Income Recipient Name	Annual Amount

If no income, indicate means of support, i.e. How are groceries, rent, etc. provided.

_____

_____

_____

DOCUMENTATION TO BE RETURNED WITH APPLICATION

- ☐ Copy of most recent tax return. (Mandatory)
- ☐ Proof of income for applicant (and spouse if applicable); (two or three) most recent pay stubs, unemployment insurance payment stubs, or sufficient information on how patients are currently supporting themselves. (Mandatory)
- ☐ Bank Statements to support all cash and investment accounts. (Mandatory when considering Income defined by any means other than AGI.)
- ☐ Medicaid denial letter dated within the most recent three month window. (Mandatory for adults with an Income at or below 125% of FPG or for children with a family Income at or below 300% of FPG.)
- ☐ Insurance card for any eligible coverage.

Additional information may be requested to validate the application which may include, but not limited to review of available assets or other financial resources. External, public sources which may be utilized, including credit scores.

I certify all information provided is true and complete. If any information is determined to be false, all Program discounts will be revoked making the patient responsible for the previously calculated balance for services rendered.

I hereby request the Richland Hospital make a determination of Community Care eligibility for active accounts of the above named individuals. I understand that accounts that have been forwarded to an outside agency for collection action are not eligible for Community Care consideration.

_____ _____

Applicant Signature Date

_____ _____

Spouse Signature (if applicable) Date

FOR RICHLAND HOSPITAL USE ONLY

_____ Date Application Received in Patient Accounting Department

☐ Yes ☐ No Application complete and signed

☐ Yes ☐ No Copy of most recent tax return
If no, copy of bank statement: ☐ Yes ☐ No

☐ Yes ☐ No Recent payroll, unemployment, stubs or other income (applicant & spouse)
If no, documentation of current financial support: ☐ Yes ☐ No

☐ Yes ☐ No Income Below 125% of FPL
If yes, proof of BadgerCare status: ☐ Approved ☐ Denied
If approved, reclass account to Badger Care.

☐ Yes ☐ No Income Below 300% of FPL with minor children
If yes, proof of BadgerCare status: ☐ Approved ☐ Denied
If approved, reclass account to BadgerCare

☐ Yes ☐ No Copy of Insurance Card, if applicable

_____ Date application given to supervisor for review or
Date patient notified if additional information is needed
Information Requested/Needed: _____

_____

_____

_____ Date additional information received.

APPLICATION STATUS

Approved: ☐ **Full** ☐ **Partial - percentage:** _____
Denied: ☐ **Income** ☐ **Missing/incomplete documentation**
☐ **BadgerCare eligible**

_____ Date patient informed of application status.

_____ If approved, date discount applied to account.