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.

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DOCUMENTATION TO BE RETURNED WITH APPLICATION

- ☐ Copy of most recent Federal tax return. (Mandatory. W2's not accepted.)
- ☐ Proof of income for applicant (and spouse if applicable); (two or three) most recent pay stubs, unemployment payment stubs, Social Security benefit statement, or sufficient information on how patients are currently supporting themselves. (Mandatory)
- ☐ Bank Statements to support all cash and investment accounts to show 3 months. (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.)

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: ______________________________________

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______________ 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.

Applications are reviewed annually.

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