



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 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 three months (mandatory when considering Income defined by any means other than adjusted gross income).
- ☐ Medicaid denial letter dated within the most recent three-month window (mandatory for adults with an income at or below 125% of federal poverty guidelines or for children with a family Income at or below 300% of federal poverty guidelines).

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 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 and Clinics 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 FPG
If yes, proof of BadgerCare status: ☐ Approved ☐ Denied
If approved, reclass account to BadgerCare
- ☐ Yes ☐ No Income below 300% of FPG 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 of additional information 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: _____