ALOMERE HEALTH
COMMUNITY UNCOMPENSATED CARE PROGRAM

WHAT IS THE COMMUNITY UNCOMPENSATED CARE PROGRAM?

Alomere Health has elected to provide a reasonable amount of services without charge or at reduced charges to people who cannot afford to pay for needed care. Under this program, the hospital elects to provide services without charge or reduced charges to eligible persons. These services include any inpatient or outpatient services routinely provided by the hospital.

HOW DO I QUALIFY FOR UNCOMPENSATED SERVICES?

Eligibility is determined by comparing family income and assets to guidelines established by the Hospital Governing Board. You must meet both income and asset requirements to qualify.

CAN I GET UNCOMPENSATED CARE SERVICES?

You may receive uncompensated services if you:

- Have made a reasonable attempt to apply for Medical Assistance within the program time constraints,
- Have net assets that are not more than the asset limits established by the Hospital Board,
- Have income that is not more than the income limits established by the Hospital Board,
- Transfer any medical insurance benefits that apply to the hospital services provided
- Services are medically necessary

HOW DO I APPLY FOR UNCOMPENSATED CARE?

If a person thinks that he or she or a family member may be eligible for uncompensated services and wishes to request it, he or she should make a request to the Account Services Department. Verification of eligibility will be required. Alomere Health will provide covered services without charge or reduced charge to all eligible persons who request uncompensated services at least until its budget for these services is exhausted.

The Hospital Board reserves the final right to approve or deny any application for uncompensated services.

FOR MORE INFORMATION

This information can help you decide if you wish to apply for Alomere Health Community Uncompensated Services. This does not cover all of the program rules. We will need all the facts about your situation before they can determine if you are eligible. For more information about Community Uncompensated Services, contact

Account Services Department

Heartland Orthopedic Specialist
111 17th Avenue E
Alexandria MN 56308
320-759-4242
800-450-6101

Alomere Health
1500 Irving Street Ste 2
Alexandria, MN 56308
320-759-4242
800-450-6101

Alexandria Clinic PA
610 30th Avenue W
Alexandria, MN 56308
320-759-4242
800-450-6101

Lakes ENT
111 17th Avenue E
Alexandria, MN 56308
320-759-4242
800-450-6101

“Alomere Health and all of its services comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alomere Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.”

COMMUNITY UNCOMPENSATED CARE APPLICATION

I hereby request that Alomere Health make a determination of eligibility for uncompensated services at Alomere Health, Alexandria Clinic, Heartland Orthopedic Specialists or Lakes ENT.

Patient Name_____ Spouse /Parent if Minor_____

Date of Birth_____ Guarantor # if Available _____

Address: _____

City, State, Zip_____

Telephone (Home):_____ (Work): _____(Cell)_____

INCOME: Income is the total of all family cash receipts **before taxes** from all sources including wages, salaries, unemployment, social security, alimony, public assistance, etc. It includes receipts from self-employment, farm or business after tax-deductible business-related expenses.

Family	100%		80%		60%		40%		20%	
Size	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly
1	25,760	2,147	27,370	2,281	28,980	2,415	30,590	2,550	32,200	2,684
2	34,840	2,904	37,018	3,085	39,195	3,267	41,373	3,448	43,550	3,630
3	43,920	3,660	46,665	3,889	49,410	4,118	52,155	4,347	54,900	4,575
4	53,000	4,417	56,313	4,693	59,625	4,969	62,938	5,245	66,250	5,521
5	62,080	5,174	65,960	5,497	69,840	5,820	73,720	6,144	77,600	6,467
6	71,160	5,930	75,608	6,301	80,055	6,672	84,503	7,042	88,950	7,413
7	80,240	6,687	85,255	7,105	90,270	7,523	95,285	7,941	100,300	8,359
8	89,200	7,434	94,775	7,898	100,350	8,363	105,925	8,828	111,500	9,292

For family units with more than eight members, add $750 per month for each additional member.

PROOF OF INCOME MUST BE INCLUDED OR APPLICATION WILL BE DENIED

	Last 3 completed calendar months	Previous Year/Federal 1040 & W2 Forms
Wages before taxes		
Self-Employment Fed 1040 &Sched C		
Farm Income Fed 1040 & Sched F		
Public Assistance		
Social Security before deductions		
Unemployment/Workers Comp		
Alimony/Child Support		
Military Family Allotments		
Pensions		
Income from interest, dividends or rent Or any Other:		
Total		

Family Size: _____ **Family Members Names** _____

OVER

What are the asset limits for uncompensated care?

Assets are what you own including cash, savings or non-homestead property. A person living alone may own $12,000 in assets. A married couple or family may own $28,000 in assets.

Assets that do not count are: Homestead property, prepaid burial fund up to $3,000, one motor vehicle, and business or farm assets used to support income stream. Asset value limits are net of what is owed against each asset.

	Yes/No	Value	Amount Owed	Owners Name
Cash				
Bank Accounts				
Life Ins/Cash Value				
Stocks/Bonds				
Burial Funds				
Motor Vehicle list make and year *if more than one*				
Non-Homestead Property				
Boat/Motorcycle, Camper,				
Other				
Total Value (net)				

If you are seeking uncompensated care for services already rendered by Alomere Health, please list the place of service and approximate dates if you have available.

_____

If you are seeking an eligibility determination for services not yet rendered, please indicate the type of service sought and approximate date service is to be rendered _____

I understand that the information I have submitted is subject to verification by the Alomere Health and

subject to final review and determination by the Alomere Health Board and others as required. By signing this application, I am declaring under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I also understand that if the information I submit is determined to be false or misleading, or if I omit relevant information requested, such a determination will result in a denial of benefits under the Uncompensated Care Program, and I will be liable for all charges for the services provided.

Signed _____Date _____

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