



Date: \_\_\_\_\_

Patient Account #: \_\_\_\_\_

## Financial Assistance Program – Imaging for a Cause

### What We know

According to our records you have received services through RAYUS Radiology, formerly CDI, in partnership with Alomere Health and your account has an outstanding balance. Through our partnership with Alomere Health you may be eligible for financial assistance.

### What We Are Doing

RAYUS Radiology may provide a reasonable amount of services without charge or at a reduced charge to those who cannot afford to pay for needed medical care.

### How Do I Qualify for Financial Assistance?

- Eligibility is determined by comparing family income to guidelines established by Alomere Health.

### How Do I Apply for Financial Assistance?

- If you believe that you or your family member may be eligible for Financial Assistance and wish to request it, an application form should be completed.

### What You Can Do

Fill out the attached form and provide the documents requested to:

#### Email

[customerservice@RAYUSRadiology.com](mailto:customerservice@RAYUSRadiology.com)

#### Fax

(952)905-5645

#### Mail

RAYUS Radiology  
Attn: Customer Service Dept  
5775 Wayzata Blvd. Suite 400  
St Louis Park, MN 55416

For additional information, please contact our business office at 866-225-6265.

### RAYUS Radiology Financial Assistance Application

I hereby request that RAYUS Radiology make a determination of eligibility for financial assistance at RAYUS Radiology. I understand that the information which I submit concerning my income, family size and assets is subject to verification by RAYUS Radiology. 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 Financial Assistance under this program; I will be liable for all charges for the services provided.

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 RAYUS Radiology's billing office at 866-225-6265 or via email at [customerservice@RAYUSRadiology.com](mailto:customerservice@RAYUSRadiology.com)

"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 RAYUS Radiology in partnership with 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	30,120	2,510	32,003	2,667	33,885	2,824	35,768	2,981	37,650	3,138
2	40,880	3,407	43,435	3,620	45,990	3,833	48,545	4,046	51,100	4,259
3	51,640	4,304	54,868	4,573	58,095	4,842	61,323	5,111	64,550	5,380
4	62,400	5,200	66,300	5,525	70,200	5,850	74,100	6,175	78,000	6,500
5	73,160	6,097	77,733	6,478	82,305	6,859	86,878	7,240	91,450	7,621
6	83,920	6,994	89,165	7,431	94,410	7,868	99,655	8,305	104,900	8,742
7	94,680	7,890	100,598	8,384	106,515	8,877	112,433	9,370	118,350	9,863
8	105,440	8,787	112,030	9,336	118,620	9,885	125,210	10,435	131,800	10,984

\*For households with more than 8 members, add \$897/mo or \$10,760/year 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:		
<b>Total</b>		

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 <i>if more than one</i>				
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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