MINIDOKA MEDICAL CENTER RHC
1308 8th St Ste 1, Rupert, ID 83350

Financial Assistance Application:
Request to Waive Coinsurance or Deductible- applies to Minidoka Medical Center RHC services only. Minidoka Memorial Hospital has a separate application process.

Patient name _____ Phone # _____

Address_____

City/State/Zip _____

Description of services to be provided _____

I hereby declare that I cannot afford to pay Minidoka Medical Center RHC the coinsurance and/or deductible for the above-described services because my gross family income is at or below 200 percent of the current federal poverty guidelines, as described in Minidoka Medical Center's Waiver of Coinsurance or Deductibles Policy.

I therefore request a waiver of the coinsurance and/or deductible for these services. I agree to notify Minidoka Medical Center RHC if my gross family income rises above 200 percent of the current federal poverty guidelines, at which time I will begin to pay any required coinsurance or deductibles. (See Federal income guidelines/other side)

Gross Monthly Household Income: $_____

Monthly Household Expenses: $_____
(total lines 1-6)

1. Mortgage/Rent: $_____
2. Utilities: $_____
3. Food: $_____
4. Car Payment: $_____
5. Medical: $_____
6. Other: $_____

Name	DOB

Number in Household (including self) _____

Income must be reported for all working age members of the household, regardless of marital status. Proof of income will be required.

Applicant must submit the following documents, as they apply to your individual situation:

1. W-2 withholding statements;
2. Pay stubs;
3. Most current income tax return;
4. **Social Security current year SSA-1099.**
5. Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
6. Forms approving or denying unemployment compensation; or
7. Written statements from employers or welfare agencies.

I declare under penalty of perjury that the above is true and accurate.

Patient signature _____ Date_____

Approved: _Yes / No % discount:_____ Verified by_____Date: _____ Policy effective date: 03.2019

ATTACHMENT C: MINIDOKA MEDICAL CENTER RHC Financial Hardship:

Discount does not apply to insurance contract required copays.

MMH Financial Assistance Discount Schedule

1/5/2021

Individuals receiving Financial Assistance are expected to pay a co-payment of the larger of $20 or 10% of the amount owed up to a maximum out of pocket of $250 per admission or per office visit.

Financial Assistance Policy, Schedule A

Family Size	Annual 2021 Federal Poverty Guidelines	Monthly 2021 Fed Poverty Guidelines	100% of 2021 Federal Poverty Guidelines	200% of 2021 Federal Poverty Guidelines
1	$12,760	$1,063	$1,063	$2,127
2	$17,240	$1,437	$1,437	$2,873
3	$21,720	$1,810	$1,810	$3,620
4	$26,200	$2,183	$2,183	$4,367
5	$30,680	$2,557	$2,557	$5,113
6	$35,160	$2,930	$2,930	$5,860
7	$39,640	$3,303	$3,303	$6,607
8	$44,120	$3,677	$3,677	$7,353
9	$48,540	$4,045	$4,045	$8,090
10	$52,960	$4,413	$4,413	$8,827

NEW PLAN

FULL W/O AT 150%	PARTIAL CHARITY AT 75%		PARTIAL CHARITY AT 50%	
$ 1,595.00	$ 1,595.00	$ 2,392.50	$ 2,392.50	$ 3,190.00
$ 2,155.00	$ 2,155.00	$ 3,232.50	$ 3,232.50	$ 4,310.00
$ 2,715.00	$ 2,715.00	$ 4,072.50	$ 4,072.50	$ 5,430.00
$ 3,275.00	$ 3,275.00	$ 4,912.50	$ 4,912.50	$ 6,550.00
$ 3,835.00	$ 3,835.00	$ 5,752.50	$ 5,752.50	$ 7,670.00
$ 4,395.00	$ 4,395.00	$ 6,592.50	$ 6,592.50	$ 8,790.00
$ 4,955.00	$ 4,955.00	$ 7,432.50	$ 7,432.50	$ 9,910.00
$ 5,515.00	$ 5,515.00	$ 8,272.50	$ 8,272.50	$ 11,030.00
$ 6,067.50	$ 6,067.50	$ 9,101.25	$ 9,101.25	$ 12,135.00
$ 6,620.00	$ 6,620.00	$ 9,930.00	$ 9,930.00	$ 13,240.00

Family Size	100% Discount Less Co-payment if Monthly Income is less than	90% Discount Less Co-Payment if Income Is		80% Discount Less Co-Payment if Income is		70% Discount Less Co-Payment if Income is		60% Discount Less Co-Payment if Income Is		50% Discount Less Co-Payment if Income Is	
		More Than	Less Than	More Than	Less Than	More Than	Less Than	More Than	Less Than	More Than	Less Than
1	$1,063	$1,062	$1,276	$1,275	$1,382	$1,381	$1,489	$1,488	$1,595	$1,594	$1,701
2	$1,437	$1,436	$1,724	$1,723	$1,868	$1,867	$2,011	$2,010	$2,155	$2,154	$2,299
3	$1,810	$1,809	$2,172	$2,171	$2,353	$2,352	$2,534	$2,533	$2,715	$2,714	$2,896
4	$2,183	$2,182	$2,620	$2,619	$2,838	$2,837	$3,057	$3,056	$3,275	$3,274	$3,493
5	$2,557	$2,556	$3,068	$3,067	$3,324	$3,323	$3,579	$3,578	$3,835	$3,834	$4,091
6	$2,930	$2,929	$3,516	$3,515	$3,809	$3,808	$4,102	$4,101	$4,395	$4,394	$4,688
7	$3,303	$3,302	$3,964	$3,963	$4,294	$4,293	$4,625	$4,624	$4,955	$4,954	$5,285
8	$3,677	$3,676	$4,412	$4,411	$4,780	$4,779	$5,147	$5,146	$5,515	$5,514	$5,883
9	$4,045	$4,044	$4,854	$4,853	$5,259	$5,258	$5,663	$5,662	$6,068	$6,067	$6,472
10	$4,413	$4,412	$5,296	$5,295	$5,737	$5,736	$6,179	$6,178	$6,620	$6,619	$7,061

Family Size	40% Discount Less Co-Payment if Income is		30% Discount Less Co-Payment if ly Income Is		20% Discount Less Co-Payment if Income is		10% Discount Less Co-Payment if Income Is		No Discount if Total Monthly Income More Than
	More Than	Less Than	More Than	Less Than	More Than	Less Than	More Than	Less Than	
1	$1,700	$1,808	$1,807	$1,914	$1,913	$2,020	$2,019	$2,127	$2,127
2	$2,298	$2,442	$2,441	$2,586	$2,585	$2,730	$2,729	$2,873	$2,873
3	$2,895	$3,077	$3,076	$3,258	$3,257	$3,439	$3,438	$3,620	$3,620
4	$3,492	$3,712	$3,711	$3,930	$3,929	$4,148	$4,147	$4,367	$4,367
5	$4,090	$4,346	$4,345	$4,602	$4,601	$4,858	$4,857	$5,113	$5,113
6	$4,687	$4,981	$4,980	$5,274	$5,273	$5,567	$5,566	$5,860	$5,860
7	$5,284	$5,616	$5,615	$5,946	$5,945	$6,276	$6,275	$6,607	$6,607
8	$5,882	$6,250	$6,249	$6,618	$6,617	$6,986	$6,985	$7,353	$7,353
9	$6,471	$6,877	$6,876	$7,281	$7,280	$7,686	$7,685	$8,090	$8,090
10	$7,060	$7,503	$7,502	$7,944	$7,943	$8,385	$8,384	$8,827	$8,827