Roosevelt General Hospital

42121 US Hwy 70
PO Drawer 868
Portales, NM 88130
575.359.1800
www.MyRGH.org

Roosevelt County Charity Application

I understand that Roosevelt General Hospital receives county funds to help subsidize the cost of services for patients whose documented gross income is below 200% of the current federal poverty level for that patient's family size.

I understand that these subsidized services are only for patients who meet the eligibility criteria and that federal regulations require that Roosevelt General Hospital at least annually certify my eligibility for subsidized services and document this certification in my permanent record.

I understand that if I qualify for subsidized services, they will be provided to me at a discount so long as I continue to qualify. I agree to inform Roosevelt General Hospital of substantial change in my economic status which could prevent me from being eligible for the subsidy. I also agree to provide updated proof of income at future visits upon request.

I understand that federal regulations require Roosevelt General Hospital to collect at least a nominal fee for services rendered and that I am expected to pay a minimum charge at each visit.

I understand that I am responsible for all charges, and that Roosevelt General Hospital may refuse future ***non-acute medical services***, and that Roosevelt General Hospital may engage a collection agency to collect from me if I fail to make timely payments. Knowing these limitations, I hereby request subsidized medical services at Roosevelt General Hospital based on the following criteria:

YOUR DOCUMENTED ANNUAL INCOME IS $_____________________.

YOUR DOCUMENTED FAMILY SIZE IS _______________.

THEREFORE YOU QUALIFY FOR (0,25,50,100%) DISCOUNT____________.

Application approved by: _____________________________ Date: ______________

I hereby certify that the income and family composition information supplied in the above tables is true and correct to the best of my knowledge. I understand this document will be maintained in my permanent record and that falsification of information may constitute a federal offense.

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I hereby authorize any medical or surgical care which is considered by the staff of Roosevelt General Hospital to be in my, or my family's best interest, and authorize the release of any information required in the course of registration, examination, or treatment.

SIGNATURE ____ DATE_____________________

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Annual Guidelines

Family Size	50%	75%	85%	100%
1	10,830.00 - 14,403.89	14,403.90 - 16,424.99	16,245.00 - 18,952.49	18,952.50 - OVER
2	14,570.00 - 19,378.09	19,378.10 - 21,854.99	21,855.00 - 26,954.49	26,954.50 - OVER
3	18,310.00 - 24,352.29	24,352.30 - 27,464.99	27,465.00 - 33,873.49	33,873.50 - OVER
4	22,050.00 - 29,326.49	29326.50 - 33,075.99	33,075.00 - 40,792.49	40,792.50 - OVER
5	25,790.00 - 34,300.69	34,300.70 - 38,685.49	38,685.00 - 47,711.49	47,711.50 - OVER
6	29,530.00 - 39,274.89	39,274.90 - 44,295.49	44,295.00 - 54,630.49	54,630.50 - OVER
7	33,270.00 - 44,249.09	44,249.10 - 49,905.49	49,905.00 - 61,549.49	61,549.50 - OVER
8	37,010.00 - 49,223.29	49,223.30 - 55,515.49	55,515.00 - 68,468.49	68,468.50 - OVER

**For family units of more than 8 members, add $3,470.00 for each additional member.*

Monthly Guidelines

Family Size	50%	75%	85%	100%
1	902.50 - 1,200.32	1,200.33 - 1,353.74	1,353.75 - 1,669.62	1,669.63 - OVER
2	1,214.17 - 1,614.83	1,614.84 - 1,821.35	1,821.25 - 2,246.20	2,246.21 - OVER
3	1,525.83 - 2,029.35	2,029.36 - 2,288.74	2,228.75 - 2,822.78	2,822.79 - OVER
4	1,837.50 - 2,443.87	2,443.88 - 2,756.24	2,756.25 - 3,399.37	3,399.38 - OVER
5	2,149.17 - 2,858.38	2,858.39 - 3,223.74	3,223.75 - 3,975.95	3,975.96 - OVER
6	2,460.83 - 3,272.90	3,272.91 - 3,691.24	3,691.25 - 4,552.53	4,552.54 - OVER
7	2,772.50 - 3,687.42	3,687.43 - 4,158.74	4,158.75 - 5,129.12	5,129.13 - OVER
8	3,084.17 - 4,101.93	4,101.94 - 4,626.24	4,626.25 - 5,705.70	5,705.71 - OVER