CENTRACARE Health

MRN -
Approved Y____N _ Initials _____

PATIENT FINANCIAL ASSISTANCE

NAME: _____
(First) (Middle) (Last)

ADDRESS: _____
(Number and Street Name) (City) (State) (Zip)

TELEPHONE: Home: _____ Cell: _____ Date of Birth: _____

EMPLOYER: _____ OCCUPATION: _____

DATE OF HIRE: _____ EMPLOYER PHONE: _____

SPOUSE NAME: First: _____ MI: _____ Last: _____

SPOUSE EMPLOYER: _____ SPOUSE DATE of BIRTH _____

DATE OF HIRE: _____ EMPLOYER PHONE: _____

DID YOU FILE TAXES LAST YEAR? Y_____ N_____ DO YOU HAVE INSURANCE? Y_____N _____

Insurance name: _____ ID# _____ Spouse ID#_____

INCOME: List income from guarantor and spouse: Monthly

Wages	
Farm or Self-Employment (must include most recent tax return)	
Public Assistance	
Social Security	
Unemployment Compensation	
Worker's Compensation	
Alimony	
Child Support	
Pensions	
Rental Income	

DEPENDENTS:

Name	Relationship	DOB	Insurance ID#

I affirm the above information is true and correct to the best of my knowledge. I also authorize CentraCare Health to verify any information listed above.

Guarantor Signature Spouse Signature (REQUIRED) Date

CENTRACARE Health

PATIENT FINANCIAL ASSISTANCE

CentraCare Health's Financial Assistance Program was established to assist patients who do not have the ability to pay for services received. If a patient meets the guidelines, the total bill or a portion of the charges may be covered. To be considered for assistance, please fill out the reverse side and return with the requested information.

In order for CentraCare to process your application, please follow the instructions below.

- Use gross income figures including spousal income, if you are married.
- If you have **NO** insurance, you **MUST** apply for medical assistance through MNSURE before you can qualify. You **MUST** also attach a copy of any medical assistance denial with this form or a print screen of your denial from the MNSURE website.
- **Please provide proof of income: If you file taxes, you are required to provide the first two pages of your most recent tax return (showing adjusted gross income) or, if you DO NOT file taxes, please provide your last four pay stubs. If you receive Social Security or are receiving unemployment, please include bank statements showing monthly/weekly deposits or your Social Security award letter. Spouse signature is required if applicable.**
- Please return the requested information in the envelope provided, or mail to CentraCare Health, 1406 Sixth Ave N Billing, St. Cloud, MN 56303.
- If you qualify, we will notify you by mail within two weeks of receiving your application.

I hereby request that CentraCare Health makes a written determination of my eligibility for patient financial assistance. I understand the information, which I submit concerning my annual income and family size, is subject to verification by CentraCare Health. I also understand if the information which I submit is determined to be false, such a determination will result in a denial. Patient or guarantor will be liable for charges for services provided. The facility will provide financial assistance at no charge or at a specified charge less than the allowable credit for the services. All possible third party payers must be explored and finalized before financial assistance status is determined. You must reside in the U.S. to be eligible for CCH Financial Assistance.

If you have any questions, please contact:

CentraCare Health, Patient Financial Services:
320-255-5613, or TOLL FREE 1-844-460-5533 Fax #-320-656-7194