Income Verification Form

This form is to verify income eligibility for an additional discount program for uninsured or eligible noncovered services received at a CentraCare hospital department. Patients that qualify would have a yearly household gross income under $125,000 and are not already covered by the CentraCare financial assistance program.

Proof of yearly income: (please provide for you and your spouse):

___Most recent 1040 tax form (if you do not file taxes please provide a full months pay stubs)

___Current Year Social Security Award/Benefit Letter

___Additional Monthly Income Proofs

Applicant Name _____

Date of Birth_____

Yearly Income $_____

Primary Phone:_____

Spouse Name_____

Date of Birth_____

Yearly Income $_____

We want to make sure that you are in the best program for your household income level - If it appears that your income would qualify you for our financial assistance program, we will be sending you an application and would ask that you apply for that program. We are committed to making sure that we assist you with the best possible path.

Please complete this form and return the signed form along with the income documents via email to financialassistance@centracare.com or send via mail to: CentraCare, Attn Patient Financial Services, 1406 6th Ave N, St Cloud MN 56303.

I certify that the above information is true and correct to the best of my knowledge.

Date_____ Signature_____