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 (You receive)	
Pensions	
Income from Rental Property	

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

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PATIENT FINANCIAL ASSISTANCE

CentraCare Health's Financial Assistance Program was established to assist patients who cannot 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.

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 your most recent 1040 Federal Tax Return (include the two pages showing your dependents and adjusted gross income) OR, if you do not file taxes, please provide your last four pay stubs. If you receive Social Security, please include your Social Security award letter. If you receive unemployment, please include your benefit determination letter showing your weekly benefits.**
- 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. I understand that if I am not a resident of the United States, I may not qualify.

If you have any questions, please contact:
CentraCare Health, Patient Financial Services:
320-255-5613, or TOLL FREE 1-844-460-5533 FAX 320-240-2834

English: CentraCare Health complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-320-255-5989 (TTY: 1-320-255-5983).

Somali: CentraCare Health waa mid u hogaansan xeerarka dawladda dhexe ee ilaalinta xuquuqda aadanaha mana ogola heyb sooc ku saleysan qowmiyadda, midabka, halka uu qofku ka soo jeedo asal ahaan, da'da, naafanimada ama jinsiga qofka. XUSUUSO: Haddii aad ku hadasho af Soomaali, adeegyo kaalmo oo dhanka luqadda, oo bilaash ah, ayaad helaysaa. Soo wac 320-255-5989 (TTY: 1-320-255-5983).

Spanish: CentraCare Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-320-255-5989 (TTY: 1-320-255-5983).