MAHNOMEN HEALTH

Dear Patient,

Mahnomen Health is committed to providing quality progressive healthcare services to all. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for our charity care program.

Enclosed with this letter, you will find a worksheet/application that demonstrates your financial condition. You must complete this document in full and submit all additional documentation listed below to receive consideration for our charity care program. If your financial situation meets the criteria set forth by Mahnomen Health, part or all of your account balance may be forgiven.

In order to process your application, we require:

- The enclosed application completed in its entirety
- Copy of last two pay stubs for any wage earner contributing to household income
- Copy of your more recent 1040 tax return, including all applicable schedules
    - If your most recent tax return is not available, please submit one of the following:
        - Social Security Awards Letter
        - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)
- Copy of your property tax assessment statement for ALL owned property

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or have any questions, please contact us at pfs@mahnomenhealth.org or 218-935-2511. Our business hours are Monday-Friday 8AM- 4:30PM.

If you feel your concerns have not been addressed, please contact us at the number above first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at 651-296-3353 or 800-657-3787.

Please return the above information to us in person or MAIL to Mahnomen Health, 414 W Jefferson Ave, Mahnomen, MN 56557.

Thank you,

Mahnomen Health Administration

Mahnomen Health
Charity Care Application

Demographic Information

Name	Date of Birth	Spouse	Date of Birth

Address	City	State	Zip

Time at Present Address: ___Rent _____Years _____Months ___Own	County	Marital Status ____Married ____Single ____Divorced ____Widowed

Cell Phone Number	Work Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number

Please list ALL dependents living in your household: (Attach an additional sheet if needed)

Last Name	First Name	MI	Date of Birth	Social Security #	Relationship to Applicant
1.					
2.					
3.					
4.					

	Spouse		Self	
Social Security #			Social Security #	
Employed By			Employed By	
Business Address			Business Address	
Occupation		Hourly Wage	Occupation	Hourly Wage
How Long Employed: ____Years ____Months ____Hours Worked Per Week			How Long Employed: ____Years ____Months ____Hours Worked Per Week	

Additional Information

Have you ever declared bankruptcy? __No __Yes __Chapter 7 __Chapter 13 Date Filed:_____ Date of Discharge:_____

Do you have any judgments or liens filed against you? If yes, please provide date and reason: _____

	Applicant Primary Insurance Coverage	Secondary Insurance Coverage	Spouse Primary Insurance Coverage	Secondary Insurance Coverage
Name:				
Address:				
Subscriber:				
ID & Group #:				

Source of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		Spouse Monthly Gross
Gross Income		Gross Income	
Social Security/SSI/SSDI		Social Security/SSI/SSDI	
Public Assistance		Public Assistance	
Rental Income		Rental Income	
Retirement/Pension		Retirement/Pension	
Veterans Benefits		Veterans Benefits	
Unemployment/Work Comp From: To:		Unemployment/Work Comp From: To:	
Child Support/Alimony From: To:		Child Support/Alimony From: To:	
Other Please Identify:		Other Please Identify:	
TOTAL		**TOTAL**	
		Combined Monthly Gross Income:	

Assets

	Location	Amt/Value		Location	Amt/Value
Checking			Certificate of Deposit (CD)		
Savings			Stocks/Bonds		
Other			Other		

Assets/Property

Motor Vehicle	Year/Make/Model	Value	Loan Balance	Lien Holder
	Year/Make/Model	Value	Loan Balance	Lien Holder
Recreational Equip (boats, snowmobiles, etc.)	Year/Make/Model	Value	Loan Balance	Lien Holder
	Year/Make/Model	Value	Loan Balance	Lien Holder
Other Property	Address, Township, County		Loan Balance	Assessed Value
	Address, Township, County		Loan Balance	Assessed Value
Homestead	Address			Assessed Value
	Township, County	Mortgage Balance		Lien Holder

Monthly Expenses

House Payment Rent	Water and Sewer	Auto Insurance	Life Insurance	
Property Taxes	Phone/Cell Phone	Food	Health Insurance	
Property Insurance	Cable TV	Daycare Exp	Medications	
Heat	Vehicle Payment	Child Support Exp	Other/Specify	
Electric	Transportation Exp	Recreational Equip	**TOTAL**	

Credit Cards/Other Exp

Creditor Name	Address	Balance	Monthly Payment
		TOTAL	
		GRAND TOTAL / CREDIT CARDS, OTHER EXPENSES AND MONTHLY EXPENSES	

How much of your Mahnomen Health Center (MHC) bill are you paying/or are able to pay per month? _____

REQUIRED DOCUMENTS:

__ Proof of all income: (i.e. 2 paystubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony or Other).

__Copy of your most recent 1040 tax return, including all applicable schedules

__Copy of your property tax assessment statement from county for all owned property.

ASSIGNMENT OF RIGHTS (Please Read Carefully)

By signing below, I certify that the information and statements contained in this Application for Financial Assistance and the documentation which I submit are accurate, true and correct to the best of my knowledge.

I understand that Mahnomen Health may make reasonable requests for additional information and verification if necessary.

I understand that the information and statements I have provided will be kept confidential by Mahnomen Health.

I understand that the completion of this application will allow Mahnomen Health to consider my circumstances.

I understand Mahnomen Health makes no representations that financial assistance is guaranteed.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

_____ _____

Signature Date

_____ _____

Signature Date