Financial Assistance Application Instructions

First Care Health Center provides financial counseling and assistance, to those who meet set criteria, for uninsured and underinsured people or limited means, without regard to race, ethnicity, sexual preference, gender, religion or national origin. Financial assistance may include full or partial charity write off or reduced monthly payments. Information can be obtained by calling our business office staff at 701.284.7500.

The Financial Assistance Application must be completed, signed and returned with all required documents to help us determine the level of availability of financial assistance.

Extraordinary collection actions, including forwarding balance to a collection agency, reporting to credit bureaus and legal action, may occur if the outstanding balance is not resolved.

Required Documentation:

A copy of your most recent tax return.
A copy of two (2) most recent pay stubs.
A copy of two (2) most recent bank statements.
A written explanation describing your need for financial assistance.
A Medicaid denial letter or proof of application, if applicable.
All pending Social Security Disability claim information, if applicable.

Family Income and Assets:

Amounts listed in this section of the application should include applicants and spouse or significant others monthly net income. Income includes earnings, unemployment compensation, workers compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments survivor benefits, pension or retirement income, interest dividends, rents, royalties, income from estates, trust, education assistance, alimony, child support, assistance from outside the household and other miscellaneous sources. It doesn't not include noncash benefits (such as food stamps and housing subsides) or capitol gains and losses.

Net Income = Gross Income less taxes.

Real Estate and Vehicles:

List all real property and vehicles owned by you and/or your spouse/significant other. Vehicles should include all automobiles, recreational vehicles, motorcycles, etc. This section should be completed even if there is no outstanding amount owed for the asset.

Monthly Expenses:

List the monthly amounts paid by you and/or your spouse/significant other for the household expenses. Do not include amount paid by roommate whose income is not included on this application

Column A, B and C totals come from amounts listed for Real Estate and Vehicles, Loans and Debts and Outstanding Medical Bills.

Signature:

The application process is incomplete unless signed by both you and your spouse/significant other.

Mailing Address:

Please mail application and all supporting documents to:
First Care Health Center
PO Box I
Park River, ND 58270

First Care Health Center
Park River, ND 58270

Please complete and return by _____

Financial Assistance Application

Date: _____ Account Number(s): _____

Responsible Party Name: _____

Social Security #: _____ Date of Birth: _____

Street of Box #: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Years There: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Employment: _____ Job Title: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Years Employed: _____

Name and age Dependent(s) other than spouse: _____

_____

Spouse/Significant Other: _____ Date of Birth: _____ Social Security #: _____

Employment: _____ Job Title: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Years Employed: _____

Does you or your spouse's employer offer insurance that you elect not to purchase? Yes ❑ No ❑

Do you have a roommate who shares the expenses? Yes ❑ No ❑

Are you seeking assistance because of a work-related accident or injury? Yes ❑ No ❑

Are you seeking assistance because of a car accident? Yes ❑ No ❑

Are you a student? Yes ❑ No ❑ If yes, are you full time? _____ part time? _____

Have you applied for any of the following: ❑Medicaid ❑Social ❑Security Disability ❑VA ❑Medicare ❑Migrant Health

Date(s) applied: _____

FAMILY INCOME		**ASSETS**	
Self **(Monthly Net)**:	$ _____	Life Insurance Cash Value:	$ _____
Spouse/Significant Other:	$ _____	Stocks/Bonds/Mutual Funds:	$ _____
(Monthly Net)		Retirement Plans:	_____
Alimony/Child Support:	$ _____	Saving Accounts:	$ _____
Income from Rental Property:	$ _____	Real Estate (Net Cash Value)	$ _____
Other:	$ _____	Other:	$ _____
Total Monthly Income:	$ _____	**Total Assets:**	$ _____

REAL ESTATE AND VEHICLES

Column A

Real Estate Description/Location	Date Acquired	Original Cost	Present Value	Balance Due	Monthly Payment
Vehicles, RV's etc.	**Year of Vehicle**	**Date Purchased**	**Purchase Price**	**Balance Owing**	**Monthly Payment**
				Total of Column A	

MONTHLY EXPENSES

Column A Total	$ _____
Column B Total	$ _____
Column C Total	$ _____
Rent	$ _____
Heat	$ _____
Electricity	$ _____
Water & Garbage	$ _____
Telephone	$ _____
Cell Phone	$ _____
Cable/Satellite TV	$ _____
Internet	$ _____
Food	$ _____
Daycare	$ _____
Medical Insurance	$ _____
Life Insurance	$ _____
Auto Insurance	$ _____
Home Insurance	$ _____
Clothing	$ _____
School	$ _____
Alimony/Child Support	$ _____
Vehicle Maintenance	$ _____
Other _____	$ _____
Other _____	$ _____
Other _____	$ _____
Total Monthly Expenses	**$ _____**

PLEASE LIST ALL LOANS/DEBTS **Column B**

Credit Card & Other Loans/Debts

If you need additional space, attach another sheet of paper

Lender	Current Balance	Monthly Payments
	Total of Column B	

OUTSTANDING MEDICAL BILLS **Column C**

Medical Facility	Current Balance	Monthly Payment
	Total of Column C	

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.

By signing this agreement, I am promising to cooperate with First Care Health Center staff and provide adequate information in a timely manner to get my bill resolved.

Signature _____ Date _____

Signature _____ Date _____