Application for Community Care

1411 Hwy 79 E Elbow Lake, MN 56531

Last Name	First	M.I.	Patients MR#
Birthdate			Social Security Number
Home Address	City	State Zip	Home Phone
			Cell Phone
Employer's Name	Employer's Address		Work Phone
			Email Address
Insurance Company Name	ID#	Subscriber's Name	Minnesota resident at time of treatment?

Is someone else responsible for your debt (spouse, legal guardian, etc.)? Yes No

Responsible party's full name and home adddress	Home Phone
	Cell Phone

Family/Household Information

Income is the total of all family cash receipts before taxes from all sources including wages, salaries, unemployment, social security, alimony, rents, public assistance, etc.

Number of individuals within your home that you are responsible for:		Is anyone else employed within your household?
Number of dependents claimed on your taxes:		

Household member's name *(if more than 3, please list on separate page)*	Household member's employer, address & phone

Family Size	PERCENT OF ANNUAL INCOME GUIDELINES AND FORGIVENESS					
	100%	80%	60%	40%	20%	
1	$ 21,245.00	$ 22,459.00	$ 23,673.00	$ 24,887.00	$ 26,101.00	For family units with more than eight persons, add $4,320.00 for each additional person.
2	$ 28,805.00	$ 30,451.00	$ 32,097.00	$ 33,743.00	$ 35,389.00	
3	$ 36,365.00	$ 38,443.00	$ 40,521.00	$ 42,599.00	$ 44,677.00	
4	$ 43,925.00	$ 46,435.00	$ 48,945.00	$ 51,455.00	$ 53,965.00	
5	$ 51,485.00	$ 54,427.00	$ 57,369.00	$ 60,311.00	$ 63,253.00	
6	$ 59,045.00	$ 62,419.00	$ 65,793.00	$ 69,167.00	$ 72,541.00	
7	$ 66,605.00	$ 70,411.00	$ 74,217.00	$ 78,023.00	$ 81,829.00	
8	$ 74,165.00	$ 78,403.00	$ 82,641.00	$ 86,879.00	$ 91,117.00	

Please provide the following information for each applicable family member and sign the certification statement below:

1) Copy of the most recent Federal tax return (1040)
2) Copy of the most recent pay stubs for all employed family members or self employment income and expenses
3) Copy of 3 months of most recent checking and/or savings bank statement
4) If applicable, copy of social Security or social Security Disability award letter
5) If applicable, copy of Unemployment Statement, disability award, or Workers' compensation award
6) If applicable, copy of Medical Flexible Spending Account or Health Spending Account funds available
7) Other income/asset sources (i.e. child support, alimony, pension, stocks, mutual funds, Certificate of Deposit, retirement income and/or letter from employer - if paid in cash, etc.)

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this bill. I understand that the information provided may be verified by Prairie Ridge Hospital & Health Services, and I authorize Prairie Ridge Hospital & Health Services to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill(s).

Applicant Signature: ________________________ **Date:** ____________

FOR OFFICE USE ONLY

Date application received:		
Date application reviewed:		
Application reviewed by:		
Professional services associated with visits:	Yes	No
TOTAL OUTSTANDING BALANCE:		
PERCENT APPROVED FOR:		