

# ***North Valley***

## **HEALTH CENTER**

### ***COMMUNITY CARE PROGRAM APPLICATION***

**Date of Request:** \_\_\_\_\_

North Valley Health Center, through our Community Care Program, offers financial assistance for healthcare services performed at our facility to eligible individuals and families. Assistance available to individuals and their families includes either reduced payments or free care based on financial need.

An individual may be eligible for the program if they:

- Have limited or no health insurance
- Are not eligible for government assistance (for example: Medicare/Medicaid)
- Can show a basis for financial need
- Provide North Valley Health Center with the necessary information about household finances

### ***ABOUT THE APPLICATION PROCESS***

The process for applying into the North Valley Health Center's Community Care Program includes these steps:

1. **Complete the North Valley Health Center Community Care Program Application Form.**
  - a. Include supporting documents noted on the documentation checklist, if applicable
  - b. Eligibility is based on family size and income
  - c. Individuals must first exhaust all insurance benefits available to them. Insurances may include, but are not limited to, Medicare, Blue Cross Blue Shield, Workers' Compensation, Automobile Insurance, Medical Assistance, etc.
  - d. North Valley Health Center can assist in directing you to the appropriate resources.
2. **Upon receipt of the application and supporting documentation, North Valley Health Center will contact you to inform you if you are eligible for the Community Care Program.**
3. **North Valley Health Center will also assist you in arranging a payment plan for any remaining balances that are not covered under the Community Care Program.**

### ***FILING YOUR APPLICATION***

Please mail your completed Community Care Program Application along with supporting documents (as indicated on the documentation checklist) to:

North Valley Health Center  
Attn: Business Office  
300 West Good Samaritan Drive  
Warren, MN 56762

If you have any questions, please contact our business office at (218) 745-4211 or (800) 950-6986 from 8:00am until 5:00pm (Monday through Friday).

Name of Guarantor/Responsible Party: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_ Alternate Telephone Number: \_\_\_\_\_

**Household Information: Please list all members of your household who were on your most recent IRS Tax Form 1040 that you would like covered under this Community Care Program Application**

NAMES	RELATIONSHIP	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have health insurance: YES \_\_\_\_\_ NO \_\_\_\_\_ Required co-pay amount: \_\_\_\_\_

If YES, please indicate type of insurance: \_\_\_\_\_

If NO, have you applied for Medical Assistance in the past six (6) months: YES \_\_\_\_\_ NO \_\_\_\_\_  
(If you have applied for Medical Assistance and have been denied, please enclose a copy of the Letter of Denial)

**Employer Information:**

*Guarantor*

Employed: YES \_\_\_\_\_ NO \_\_\_\_\_ If NO, how long: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Gross Wages: \_\_\_\_\_

*Spouse*

Employed: YES \_\_\_\_\_ NO \_\_\_\_\_ If NO, how long: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Gross Wages: \_\_\_\_\_

Do any other individuals contribute financially to the family: YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, please describe: \_\_\_\_\_

**Monthly Household Income:** Please include monthly income for yourself and other household members. Please also attach copies of your IRS Tax Form 1040 and other proof of income documents (as indicated on the document checklist).

	<u>SELF</u>	<u>SPOUSE/DEPENDENTS</u>
<u>Wages</u>	<u>\$</u>	<u>\$</u>
<u>Social Security</u>		
<u>Pension/Retirement</u>		
<u>Dividends/Interest</u>		
<u>Rents/Royalties</u>		
<u>Unemployment</u>		
<u>Workers' Comp</u>		
<u>Alimony/Child Support</u>		
<u>Other Income</u>		
<u>Total Monthly Income</u>	<u>\$</u>	<u>\$</u>

**Other: (Please Describe)**

**Please use the following space to describe your personal situation and any other additional reasons to support your request to take part in the Community Care Program:**

***NVHC DISCLAIMER:***

Your submitted information is for internal use only and will not be distributed to any other parties. We will not sell, rent, or loan any identifiable information regarding our patients to any third party. Any information you give us is held with the utmost care and security, and will not be used in ways to which you have not consented.

***GUARANTOR DISCLAIMER:***

I understand that the information that I have provided will be used to determine eligibility into the North Valley Health Center Community Care Program and that this information will be kept confidential.

I understand that the materials sent to prove my income, assets, and liabilities will not be returned. I further understand that the information submitted concerning my family income and family size is subject to verification by North Valley Health Center.

I understand that if any information given is determined to be false, it may result in the reversal of acceptance into the North Valley Health Center Community Care Program and that I will be liable for the full amount of the charges of any unpaid bill affected by the Community Care Program process.

My signature authorized North Valley Health Center to verify all information provided by me on this form. I certify that the above information to be true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE USE ONLY:**

APPROVED:        YES \_\_\_\_\_    NO \_\_\_\_\_

If NO, please indicate reason:

If YES, discount:        100% \_\_\_\_\_    60% \_\_\_\_\_    30% \_\_\_\_\_

Business Office Manager Signature: \_\_\_\_\_

CEO or CFO Signature: \_\_\_\_\_

# *North Valley*

## HEALTH CENTER

### COMMUNITY CARE PROGRAM

#### *DOCUMENTATION CHECKLIST*

IF YOU HAVE INCOME:	YES	NO	N/A
1. A copy of your most recent IRS Federal Income Tax Form 1040	_____	_____	_____
a. If you did not file a federal income tax return, you must:			
i. State in writing that you are not required to file and the reason why (Attachment A)	_____	_____	_____
ii. Send a copy of the most recent federal income tax return of anyone who claimed you as a dependant	_____	_____	_____
2. Copies of your two most recent paycheck stubs from all employers	_____	_____	_____
3. Copies of your two most recent bank statements (All Sources)	_____	_____	_____
<b>IF YOU HAVE NO INCOME:</b>			
1. If possible, please provide a Federal or State benefit agency document that shows zero income.	_____		
2. Please send us a letter of support (The person who provides your support must also sign the letter)	_____	_____	_____
3. Copies of your two most recent bank statements (All Sources)	_____	_____	_____
<b>IF YOU HAVE INSURANCE:</b>			
1. A copy of your insurance agreement indicating your deductible and required co-pay amount	_____	_____	_____
2. A copy of your proof of insurance card, if not already on file	_____	_____	_____
<b>IF YOU HAVE NO INSURANCE:</b>			
1. A copy of your letter of denial from Medical Assistance (if you have not applied for Medical Assistance – NVHC can assist you with this step, if needed)	_____	_____	_____
<b>COMMUNITY CARE PROGRAM APPLICATION:</b>			
1. A signed and completed copy of the application form	_____	_____	_____