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 From 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).

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

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 DICSLAIMER:

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: ____

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DOCUMENTATION CHECKLIST

	YES	NO	N/A
IF YOU HAVE INCOME:			
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)	____	____	____
IF YOU HAVE NO INCOME:			
1. Please send us a letter of support (The person who provides your support must also sign the letter)	____	____	____
IF YOU HAVE INSURANCE:			
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	____	____	____
IF YOU HAVE NO INSURANCE:			
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)	____	____	____
COMMUNITY CARE PROGRAM APPLICATION:			
1. A signed and completed copy of the application form	____	____	____