CentraCare™

Guarantor Name
Address
Address

CentraCare is proud to be your partner in health. We are contacting you to determine your eligibility for financial assistance. **Please complete the enclosed application (both pages), including the income and asset page.**

If you do not have insurance, you **MUST** apply for medical assistance through MNSURE before you can quality for financial assistance. You **MUST** also attach a copy of any medical assistance denial with this form or a print screen of your denial from the MNSURE website. In addition, everyone in your household must have insurance or provide copy of their medical assistance denial.

Please include a copy of all the following items if applicable:

- ☐ Most recent 1040 Federal tax return
- ☐ Last 4 most recent paystubs for you and your spouse
- ☐ Last 3 bank statements for you and your spouse
- ☐ Unemployment history page showing your weekly unemployment benefits
- ☐ Social Security Award letter or Form SSA 1099 – Social Security benefit statement
- ☐ Pension benefit letter

Please note that failure to send all information could result in a denial of assistance. It is important to make sure all of your documents are included with your application.

Please return the requested information to us via email to financialassistance@centracare.com or mail to:

CentraCare Health
1406 Sixth Ave N
St. Cloud, MN 56303.

If approved for financial assistance, you may still be asked for copays upon check-in for services, as the admission staff does not have access to your financial records. Your copay will be adjusted according to your financial assistance award guidelines and you will be sent a refund if appropriate.

If you have any questions, please contact our billing office:

CentraCare, Patient Financial Services:
Ph: 320-255-5613 or toll free-844-460-5533
FAX 320-656-7194

CentraCare™

MRN –
Approved: Y____ N____ Initials _____

PATIENT FINANCIAL ASSISTANCE

NAME: First _____ MI _____ Last _____

ADDRESS: _____
(Number and Street Name) (City) (State) (Zip)

PHONE: Home: _____Cell: _____ DATE OF BIRTH: _____

EMPLOYER: _____ OCCUPATION:_____

DATE OF HIRE:_____ EMPLOYER PHONE:_____

SPOUSE NAME: First _____ MI _____ Last _____

SPOUSE EMPLOYER: _____ SPOUSE DATE OF BIRTH: _____

DATE OF HIRE: _____ EMPLOYER PHONE:_____

DID YOU FILE TAXES LAST YEAR? Y _____ N_____

DO YOU HAVE A BANK CHECKING OR SAVINGS ACCOUNT? Y_____ N_____

DO YOU HAVE INSURANCE? Y____ N____

Insurance name: _____ID#-_____Spouse ID# _____

*If you have **NO** insurance, you **MUST** apply for medical assistance through MNSURE before you can qualify

DEPENDENTS:

Name	Relationship	DOB	Insurance ID#

I affirm the above information is true and correct to the best of my knowledge. I also authorize CentraCare Health to verify any information listed above.

_____ _____ _____
Guarantor Signature Spouse Signature (required if married) Date

PATIENT FINANCIAL ASSISTANCE

CentraCare Health's Financial Assistance Program was established to assist patients who do not have the ability to pay for services received. If a patient meets the guidelines, the total bill or a portion of the charges may be covered. To be considered for assistance, please fill out the application completely and return with the requested information.
In order for CentraCare to process your application, please follow the instructions below.

- Use gross income figures including spousal income if you are married.

- If you have **NO** insurance, you **MUST** apply for medical assistance through MNSURE before you can qualify. You **MUST** also attach a copy of any medical assistance denial with this form or a print screen of your denial from the MNSURE website. Everyone in your household must have insurance or provide a copy of their medical assistance denial.

- **Please provide proof of income. If you file taxes, you are required to provide your most recent 1040 Federal Tax Return (include the two pages showing your dependents and adjusted gross income).**

- **If you receive Social Security, please include your Social Security award/benefit letter.**
- **If pension is received, please provide pension benefit letter.**
- **Please provide your last 3 months bank statements (include spouse info)**
- **Please provide your last 4 pay stubs (include spouse info)**
- **If you receive unemployment, please include your benefit determination letter and history page showing your weekly benefits.**

- Please return the requested information in the envelope provided, or mail to CentraCare Health, 1406 Sixth Ave N, St. Cloud, MN 56303.

- If you qualify, we will notify you by mail within two weeks of receiving your application.

I hereby request that CentraCare Health makes a written determination of my eligibility for patient financial assistance. I understand the information, which I submit concerning my annual income and family size, is subject to verification by CentraCare Health. I also understand if the information which I submit is determined to be false, such a determination will result in a denial. Patient or guarantor will be liable for charges for services provided. The facility will provide financial assistance at no charge or at a specified charge less than the allowable credit for the services. All possible third-party payers must be explored and finalized before financial assistance status is determined. You must reside in the U.S. to be eligible for CentraCare Financial Assistance.

If you have any questions, please contact:
CentraCare Health, Patient Financial Services:
320-255-5613 or toll free-844-460-5533 FAX 320-656-7194

FINANCIAL ASSISTANCE APPLICATION FOR CENTRACARE AND CARRIS HEALTH ENTITIES

***Please Provide Monthly Income for Account Holder and for Spouse**

Monthly Income:			
Wages	$ /month	Unemployment	$ /month
Pension/Retirement	$ /month	Social Security	$ /month
Alimony/Child support	$ /month	Income from Rental Property	$ /month
Other Income	$ /month		

****If Liquid Assets are greater than $500,000 you are not eligible for Financial Assistance**

Liquid Assets: **(assets transferable to cash)**			
Checking Account	$	Health Savings Account	$
Savings Account	$	Pension/Retirement	$
IRA/ CD's	$	Recreational Vehicles: Campers, boats, motorcycles	Value: $ Amount Owed: $
Property (does not include your home)	$	Other assets:	$

*****Need to complete information below only if assets are over $300,000**

Expenses:			
Rent/Mortgage	$ /month	Phone	$ /month
Utilities	$ /month	Day Care	$ /month
Child Support	$ /month		$ /month
Other Expenses	$ /month		$ /month

English:
CentraCare Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-320-255-5989 (TTY: 1-320-255-5983).

Somali:
CentraCare Health waa mid u hogaansan xeerarka dawladda dhexe ee ilaalinta xuquuqda aadanaha mana ogola heyb sooc ku saleysan qowmiyadda, midabka, halka uu qofku ka soo jeedo asal ahaan, da'da, naafanimada ama jinsiga qofka. XUSUUSO: Haddii aad ku hadasho af Soomaali, adeegyo kaalmo oo dhanka luqadda, oo bilaash ah, ayaad helaysaa. Soo wac 320-255-5989 (TTY: 1-320-255-5983).

Spanish:
CentraCare Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-320-255-5989 (TTY: 1-320-255-5983).

5100402 revised 010820