Application for Financial Assistance

Lake Region HEALTHCARE
712 Cascade St S | Fergus Falls, MN 56537

Last Name	First	M.I.	Birth Date	Patient's MRN:
				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? ☐ Yes ☐ No

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

Responsible party's full name and home address:	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: _____ Number of dependents claimed on your taxes: _____	Is anyone else employed within your household? ☐ Yes (complete information below) ☐ No

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

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Family Size	PERECENT OF ANNUAL INCOME GUIDELINES AND FORGIVENESS				
	100%	80%	60%	40%	20%
1	$25,515.00	$26,973.00	$28,431.00	$29,889.00	$31,347.00
2	$34,510.00	$36,482.00	$38,454.00	$40,426.00	$42,398.00
3	$43,505.00	$45,991.00	$48,477.00	$50,963.00	$53,449.00
4	$52,500.00	$55,500.00	$58,500.00	$61,500.00	$64,500.00
5	$61,495.00	$65,009.00	$68,523.00	$72,037.00	$75,551.00
6	$70,490.00	$74,518.00	$78,546.00	$82,574.00	$86,602.00
7	$79,485.00	$84,027.00	$88,569.00	$93,111.00	$97,653.00
8	$88,480.00	$93,536.00	$98,592.00	$103,648.00	$108,704.00

For households with more than eight persons, add $8,995.00 for each additional person.

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 3 months of 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 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 Lake Region Healthcare, and I authorize Lake Region Healthcare 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:	