Financial Assistance Application Instructions

Altru Health System provides financial counseling and assistance, to those who meet set criteria, for uninsured and under-insured people of limited means, without regard to race, color, sex, national origin, disability, religion, age, sexual orientation, or gender. Financial assistance may include full or partial charity write off, community care or reduced monthly payments. More Information can be found by visiting this link or by calling our Business Office staff at 701.780.1500 or 800.464.7574.

The Financial Assistance Application must be completed, signed, and returned with all required documents to help us determine the level of availability of financial assistance. Extraordinary collection actions, including forwarding balance to a collection agency, reporting to credit bureaus and legal action, may occur if the outstanding balance is not resolved.

AHS has multiple charity programs, for the National Health Service Corps (NHSC) program AHS will not collect assets and will only collect family size and income.

Required Documentation: (Applications returned without required documentation will not be processed.)

- ☐ ***A complete copy or your most recent tax return.***
- ☐ ***Income verification to include a copy of two (2) most recent pay stubs, unemployment benefits, or social security benefits letter.***
- ☐ ***A complete copy of two (2) most recent bank statements (to verify expenses).***
- ☐ ***A written explanation describing your need for financial assistance.***
- ☐ ***A Medicaid denial letter or proof of application, if applicable.***
- ☐ ***All pending Social Security Disability claim information, if applicable.***

Family Income:

» Amounts listed in this section of the application should include applicant's and spouse's or significant other's monthly gross income. Income includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans payments survivor benefits, pension or retirement income, interest dividends, rents, royalties, income from estates, trust, education assistance, alimony, child support, assistance from outside the household and other miscellaneous sources. It does not include noncash benefits (such as food stamps and housing subsidies) or capital gains and losses.

Monthly Expenses:

» List the monthly amounts paid by you and/or spouse/significant other for household expenses. Do not include expenses paid by a roommate, only your portion of shared expenses.

» Expenses will be used to help determine payment plans along with helping to identify if any other assistance may be available.

Signature:

» The application is incomplete unless it is signed by both you and your spouse/significant other.

Mailing Address:

» If unable to complete the online application, please mail application and all supporting documents to:

Altru Health System
P.O. Box 13780
Grand Forks, ND 58208-3780

Financial Assistance Application

Instructions: Complete application and attach copies of:

- Tax returns and supporting schedules (most recent year)
- Two (2) most recent pay stubs, unemployment benefits, or social security benefits letter*
- Two (2) most recent bank statements for all accounts*
- Written explanation describing your need for financial assistance*
- A Medicaid denial letter or proof of application
- Pending Social Security Disability claim information*

** Not applicable for NHSC Sliding Fee Program*

(complete fields or place patient label here)

Date:	
Patient Name *(First, Middle, Last)*	
Birthday	Altru MRN Number
Account Number(s):	

☐ Yes ☐ No Reason: _____

I have a roommate who shares expenses.

☐ Yes ☐ No Reason: _____

I am seeking assistance because of a work-related accident or injury.

☐ Yes ☐ No Reason: _____

I am seeking assistance because of a car accident.

☐ Yes ☐ No Reason: _____

I am a student.

☐ Yes ☐ No If Yes: ☐ Full time ☐ Part Time

I have applied for:				
☐ Medicaid	☐ VA	☐ Medicare	☐ Social Security Disability	☐ Migrant Health
Date Applied:	Date Applied:	Date Applied:	Date Applied:	Date Applied:

Responsible Party Information				
Name *(First, Middle, Last)*:		Date of Birth:		Social Security Number:
Address:				Apt. #
City:	State:	Zip Code:	Years There:	Marital Status:
Home Phone:	Cell Phone:		Household Size *(Patient, Spouse, and Dependents):*	
Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Unemployed ○ Student				
Employer Name:	Employment Length:		Unemployed Date/Length *(mm-dd-yyyy)*	
Employer Phone:	Are you claimed on another tax return? *(If yes provide tax returns of those being claimed)*		☐ Yes	☐ No

Dependent (other than spouse) Information			
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

Spouse/Partner Information		
Name *(First, Middle, Last)*:	Date of Birth *(First, Middle, Last)*:	Social Security #:
Home Phone:	Cell Phone:	Employer Name:
Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Unemployed ○ Student		
Employment Length:	Unemployed Date/Length *(mm-dd-yyyy)*:	

Household Expense Information

(Used for payment plan and additional assistance determination)

Verifiable Expenses *(See Instructions)*	
Type	**Monthly Total**
Mortgage/Rent	$
Heat	$
Electricity	$
Water & Garbage	$
Telephone	$
Cell Phone	$
Cable/Satellite	$
Food/Household Supplies	$
Daycare	$
Medical Insurance	$
Life Insurance	$
Auto Insurance	$
Home Insurance	$
Vehicle Payment	$
Gas/Vehicle Maintenance	$
School	$
Alimony/Child Support	$
Other	$
Other	$
Other	$
Other	$
TOTAL A	**$**

Credit Card & Loan Debt			
Lender	**Current Balance**		**Monthly Payment**
	$		$
	$		$
	$		$
	$		$
	$		$
	TOTAL B	**$**	

Outstanding Medical Bills			
Medical Facility	**Current Balance**		**Monthly Payment**
	$		$
	$		$
	$		$
	$		$
	$		$
	TOTAL C	**$**	

Total Expenses	
TOTAL A AMOUNT	**$**
TOTAL B AMOUNT	**$**
TOTAL C AMOUNT	**$**
TOTAL EXPENSES (Add A + B + C)	**$**

Household Income Information

Bank Account(s) *Not applicable for NHSC Sliding Fee Program*			
Bank Name	**Account Type**	**Bank Name**	**Account Type**

Property *Not applicable for NHSC Sliding Fee Program*			
Type	**Detail and/or Number of Acres**	**Estimated Value**	**Unpaid Balance**
Land			
Land			
Land			
Land			

Family Household Income *(Inlcude all family in household or provider support)*	
Income Type	**Monthly Income Amount**
Self	$
Spouse/Partner	$
Alimony	$
Child Support	$
Disability	$
Interest/Dividends	$
Pension/Retirement	$
Income from Rental Property	$
TOTAL MONTHLY INCOME	**$**

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me. By signing this agreement, I am promising to cooperate with Altru Health System staff and provide adequate information in a timely matter to get my bill resolved. Providing any false information will disqualify an applicant from program participation.

Signature _____ Date _____

Signature _____ Date _____

After hitting the "submit button" and prior to sending the email, please add attachments of the following documents (Applications without attachments will not be accepted):

- ✓ A complete copy or your most recent tax return.
- ✓ All pending Social Security Disability claim information, if applicable
- ✓ A Medicaid denial letter or proof of application, if applicable
- ✓ Two (2) most recent pay stubs, unemployment benefits, or social security benefits letter*****
- ✓ Two (2) most recent bank statements from each banking account*****
- ✓ A written explanation describing your need for financial assistance*****

*****_Not applicable for NHSC Sliding Fee Program_