Altru HEALTH SYSTEM

Please complete and return by _____

Financial Assistance Application

Date: _____ Account Number(s): _____

Responsible Party Name: _____

Social Security #: _____Date of Birth:_____

Street or PO Box: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Years There: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Employment:_____ Job Title: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Years Employed: _____

Name and age Dependent(s) other than spouse: _____

_____

Spouse/Significant Other:_____Date of Birth: _____ Social Security #: _____

Employment:_____ Job Title: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Years Employed: _____

Does you or your spouse's employer offer insurance that you elect not to purchase? Yes ☐ No ☐

Do you have a roommate who share the expenses? Yes ☐ No ☐

Are you seeking assistance because of a work-related accident or injury? Yes ☐ No ☐

Are you seeking assistance because of a car accident? Yes ☐ No ☐

Are you a student? Yes ☐ No ☐ If yes, are you full time?_____ part time?_____

Have you applied for any of the following: ☐ Medicaid ☐ Social Security Disability ☐ VA ☐ Medicare ☐ Migrant Health

Date(s) applied:_____

FAMILY HOUSEHOLD INCOME (Include all family in household or providing support)

Self **(Monthly Gross)**: $ _____

Spouse/Significant Other/
Other Family:
(Monthly Gross): $ _____

Alimony/Child Support: $ _____

Income from Rental Property: $ _____

Other/Assistance: $ _____

Total Monthly Income: $ _____

VERIFIABLE MONTHLY EXPENSES
(see instructions)

Mortgage/Rent $ _____
Heat $ _____
Electricity $ _____
Water & Garbage $ _____
Telephone $ _____
Cell Phone $ _____
Cable/Satellite TV $ _____
Internet $ _____
Food/Household Supplies $ _____
Daycare $ _____
Medical Insurance $ _____
Life Insurance $ _____
Auto Insurance $ _____
Home Insurance $ _____
Vehicle Payment $ _____
Gas/Vehicle Maintenance $ _____
School $ _____
Alimony/Child Support $ _____
Other _____ $ _____
Other _____ $ _____
Other _____ $ _____

Total $ _____

PLEASE LIST ALL LOANS/DEBTS

Credit Card & Other Loans/Debts *If you need additional space, attach another sheet of paper.*		
Lender	**Current Balance**	**Monthly Payments**
	Total	

Outstanding Medical Bills

Medical Facility	**Current Balance**	**Monthly Payment**
	Total	

Total of All Expenses $ _____

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 _____

Financial Assistance Application Instructions

Altru Health System provides financial counseling and assistance, to those who meet set criteria, for uninsured and underinsured people of limited means, without regard to race, ethnicity, sexual preference, gender, religion or national origin. Financial assistance may include full or partial charity write off, community care or reduced monthly payments. Information can be found at altru.org/financialassistance 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.

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 or significant other's monthly gross income. Income includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's 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 capitol 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.

Signature:

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

Mailing Address:

» Please mail application and all supporting documents to:

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