Altru 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 assistance write-off or reduced monthly payments. More Information can be found by visiting https://www.altru.org/patients-visitors/billing-insurance/financial-assistance or by calling our HERO team at 701-780-5060.

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.

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 three (3)* most *recent pay stubs, unemployment benefits, or social security benefits letter.***
- ***A complete copy of three (3) most recent bank statements from all accounts (to verify expenses}.***
- ***A written explanation describing your need for financial assistance.***
- ***Or a written letter of support why a required document is unavailable/missing***

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.

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

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

Responsible Party Information				
Name *{First, Middle, Last):*		Date of Birth:		Social Security Number:
Address:				I 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:	I Age:	I Name:	I Age:
Name:	I Age:	I Name:	I 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	O self Employed	O unemployed O student
Employment Length:	Unemployed Date/Length *(mm-dd-yyyy):*		

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

Bank Name	Account Type	Bank Name	Account Type

Family Household Income *(include 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 completing the application, please mail the application and below required documents to Altru Health System, P.O. Box 13780, Grand Forks, ND 58208-3780 or drop the application off to the Admitting area at the hospital:

- Tax returns and supporting schedules (most recent year)
- Three (3) most recent pay stubs, unemployment benefits, or social security benefits letter*
- Three (3) most recent bank statements for all accounts*
- Written explanation describing your need for financial assistance*
- Or a written letter of support why a required document is unavailable/missing*

**Not applicable for NHSC Sliding Fee Program*