Financial Assistance

Perham Health is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance with our health system.

Enclosed with this letter, you will find a worksheet/application that demonstrates your financial condition. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Perham Health, part or all of your account balance may be forgiven.

In order to process this application we require:

- **The enclosed application completed in its entirety**
- **Copy of last two pay stubs for any wage earner contributing to household income**
- **Copy of your most recent 1040 tax return, including all applicable schedules**
- **If your most recent tax return is not available, then we need one of the following:**
  - **Social Security Awards Letter**
  - **Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
- **Copy of your property tax assessment statement from county for any owned property**
- **Copy of your most recent bank statement**
- **Medical Assistance denial**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or have any questions, please contact us at 218-347-1353. Our business hours are Monday - Friday 8am – 4:30pm.

To Minnesota residents receiving service at Perham Health: If you feel that your concerns have not been addressed, please contact Perham's Patient Financial Services at 218-347-4500 first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at 651- 296-3353 or 800-657-3787.

Please respond to this request for information within 30 days and return to our office by
SECURE FAX at 218-347-1656 or
MAIL to
Perham Health
Route 1353
1000 Coney Street West
Perham, MN 56573.

Thank you for your business.

Sincerely,
Perham Health

Financial Assistance Application

PerhamHealth
SANFORD

Accounts: _____

_____

_____

Date Sent:_____

Return By:_____

Return all applications to:

Perham Health
Route 1353
1000 Coney Street West
Perham, MN 56573
(218) 347-4500

Demographic Information

Name	Date of Birth	Spouse	Date of Birth

Address	City	State	Zip

Time at Present Address: ____Years ____Months	__Rent __Own	County	Marital Status ___Married ___Single ___Divorced ___Widowed

Cell Phone Number	Work Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number

Please list all dependents living in your household: (Attach an additional sheet if needed)

Last Name First Name MI	Date of Birth	Social Security #	Relationship to Applicant
1.			
2.			
3.			
4.			

Additional Information

Self				**Spouse**			
Social Security #				Social Security #			
Employed By				Employed By			
Business Address				Business Address			
Occupation		Hourly Wage		Occupation		Hourly Wage	
How Long Employed:	Years Months	Hours Worked Per Week		How Long Employed:	Years Months	Hours Worked Per Week	

Have you ever declared bankruptcy? __ No __ Yes __ Chapter 7 __ Chapter 13 Date Filed:_____ Date of Discharge: _____

Do you have any judgments or liens filed against you? If yes, please provide date and reason: _____

	Applicant Primary Insurance	Secondary Insurance Coverage	Spouse Primary Insurance	Secondary Insurance Coverage
Name:				
Address:				
Subscriber:				
ID & Group #:				

Source Of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		**Spouse Monthly Gross**
Gross Income		Gross Income	
Social Security / SSI / SSDI		Social Security / SSI / SSDI	
Public Assistance		Public Assistance	
Rental Income		Rental Income	
Retirement/Pension		Retirement/Pension	
Veterans Benefits		Veterans Benefits	
Unemployment / Work Comp From: To:		Unemployment / Work Comp From: To:	
Child Support / Alimony From: To:		Child Support / Alimony From: To:	
Other Please Identify:		Other Please Identify:	
TOTAL		**TOTAL**	

Combined Monthly Gross Income:

Assets		Location	Amt/Value		Location	Amt/Value
	Checking			Certificate of Deposit (CD)		
	Savings			Stocks/Bond s		
	Other			Other		

REQUIRED DOCUMENTS:

___ Proof of all income:(i.e. 2 most recent paystubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, or Other).
___ Copy of your most recent 1040 tax return, including all applicable schedules.
___ Copy of your property tax assessment statement from county for all owned property
___ Copy of most recent bank statement
___Copy of Letter of denial from Medical Assistance if Applicable
I (have) or (will) be applying for assistance in w

_____County,_____State.

ASSIGNMENT OF RIGHTS (Please Read Carefully)
By signing below I certify that the information and statements contained in this Application for Financial Assistance and the documentation which I submit are accurate, true and correct to the best of my knowledge.
I understand that Perham Health may make reasonable requests for additional information and verification if necessary. I understand that the information and statements I have provided will be kept confidential by Perham Health.
I understand that the completion of this application will allow Perham Health to consider my circumstances. I understand Perham Health makes no representations that financial assistance is guaranteed.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

_____ _____ _____ _____

Signature Date Signature Date