grand itasca™
Clinic & Hospital
1601 GOLF COURSE RD | GRAND RAPIDS MN 55744

For internal use only: GI6

Addressee

Thank you for choosing Grand Itasca Clinic and Hospital for your healthcare needs.

Please complete the enclosed Community Care application and return as soon as possible with the following documents:

-Denial letter for Medical Healthcare Programs, which must include all pages of the Medical Assistance denial.
-Proof of income for the last 3 months, for all members of your household to include check stubs or a letter from the employer showing proof of wages. This would include any statements from social security/disability, unemployment, or if you are self employed, we need copies of your company's income statement.
-Tax returns from the previous year, including all schedules
-Previous 2 month's bank statements on all bank accounts
-Copies of the previous month's bills on expenses if not shown on the bank statements.
-Current property tax statements
-Proof of assets, such as IRA, CD's, Retirement Funds, etc. or other financial resources

Please complete the application in full with copies of the required documents. If required documentation does not apply, please explain in detail. Without the required documentation listed, your application will be considered incomplete. An incomplete application will be returned, which will delay processing time. Applications are reviewed and approved by a committee including, but not limited to, the Chief Financial Officer and Business Services Manager. Eligibility for the Community Care is based on Federal Poverty Guidelines for low-income patients who are underinsured and/or uninsured and are unable to pay in full for their healthcare.

If you have any questions or need help in completing this application, please call (218) 999-1710 or (800) 662-5770.

Please return the attached application to the Financial Advocates with the above documentation within 30 days for consideration. They are located in the front area of the clinic registration.

Your time and cooperation are greatly appreciated! Thank you very much for helping us help you.

Grand Itasca Clinic and Hospital

GRAND ITASCA CLINIC & HOSPITAL COMMUNITY CARE
Application for Financial Assistance

A. RESPONSIBLE PARTY

First Name _____ Last Name _____ Int. _____
Address _____City _____ State _____ Zip Code _____
Phone ( ) _____ - _____ Date of Birth ____/___/___ Relationship to Patient _____

B. DEPENDENTS (Including Spouse)

Name(s)	D.O.B.	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Members of Your Household

Name(s)	Relationship
_____	_____
_____	_____

C. EMPLOYER _____ Your Occupation _____
Employer's Phone # ( ) ____ - _____ Current rate of pay _____ **(Please include copies of recent pay stubs or unemployment benefits.)**

Does your employer offer you health insurance? Yes ___ No ___ (check one)

D. ASSETS/INCOME

Value of Checking Account: $ _____
Value of Savings Account: $ _____
Value of Stocks/Bonds: $ _____
Total income reported on most recent Federal Tax return*: $ _____
Total Income reported on Federal Tax return for household members: $ _____
Income from Child Support: $ _____
Income from Alimony: $ _____

*** (Please attach a copy of your most recent Federal Tax return; incomes must be verified. Students who are claimed by parents as dependents for tax purposes, must include both parents' and the student's tax returns.)**

E. MONTHLY EXPENSES	Unpaid Balance	Monthly Balance
Rent/Mortgage:	$ _____	$ _____
Medical (Doctor, hospital, medications):	$ _____	$ _____
Credit Cards and Loans:	$ _____	$ _____
Groceries:	$ _____	$ _____
Utilities:	$ _____	$ _____
Auto Loan/Gas/Repairs:	$ _____	$ _____
Child Care:	$ _____	$ _____
Insurance Premiums:	$ _____	$ _____
Other:	$ _____	$ _____
TOTAL MONTHLY EXPENSES	$ _____	$ _____
TOTAL MONTHLY INCOME:	$ _____	$ _____

Additional information you would like to convey: _____

_____

The information on this application is true and correct to the best of my knowledge. I authorize Grand Itasca Clinic & Hospital to verify this information with my employer, bank, or any other financial institution or credit reporting agency.

Date _____ Guarantor's Signature _____

Date _____ GICH Staff Signature _____

Full eligibility _____ Partial eligibility _____ Not eligible _____

Please return completed application and income verification to Grand Itasca Clinic and Hospital, Attn: Financial Advocates. For any questions please call (218) 999-1710 or (800) 662-5770. GICH Management reserves the right to modify this program.