Please complete and return by _____

Financial Assistance Application

Date:_____

Name: _____ Account Number(s): _____

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: _____

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

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

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

Are you a student? Yes o No o If yes, are you full time?_____part time?_____

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

Date(s) applied:_____

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	$
Internet	$
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)			
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 **(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 Yorhom Medical Essentials 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

Yorhom Medical Essentials provides financial assistance to those who meet set criteria, for uninsuredand 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 obtained by calling the Yorhom Business Office at 701.780.1062.

The Financial Assistance Application must be completed, signed and returned with all required documents to help 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.

Household Expense Information:

List the monthly amounts paid by you and/or spouse/significant other for household expenses. Do not include amount paid by 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.

Household Income Information:

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, 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 capital gains and losses.

Guarantor's Financial Status

A guarantor's financial status may change over time and it is the guarantor's responsibility to inform Yorhom Medical Essentials of such changes. Yorhom Medical Essentials reserves the right to review enrolled applicant's eligibility at any time. The guarantor's potential for earning is considered during the review process and may result in interim arrangements with the expectation of full payment with future earnings.

Required Documentation:

» A copy or your most recent tax return.

» A copy of two (2) most recent pay stubs, unemployment benefits, or social security benefits letter.

» A copy of two (2) most recent bank statements,

» 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.

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:

Yorhom Medical Essentials

P.O. Box 6011

Grand Forks, ND 58206-6011