Thank you for your interest in Fairview's Charity Care program. Please use the enclosed form to apply for this program. Send your completed application within 30 days to:

Fairview Range
Attention: Patient Financial Services
750 E 34th St
Hibbing, MN 55746

Applications that are incomplete or missing information may be returned.

Please complete and sign the application form. If any requested information does not apply to you, please put "N/A" (not applicable) in the space provided.

- List the names and birth dates for each family member applying for the program. If you do not list them on the form, they will not be included.
- If your spouse is also applying for the program, both of you must sign the form.
- Your family size is the number of supported family members in your household. This would include a spouse and any legal dependents.

The following items must be enclosed: We will keep your records confidential (private). Please include records for all adults in your household.

- ☐ A copy of your prior year 1040 Federal Income Tax form (pages 1 and 2 showing adjusted gross income only) along with any schedules.
- ☐ Proof of current income:
    - Last two (2) pay stubs showing year to date gross income
    - Current bank statement showing checking and savings information
    - Social Security Proof of Benefits
    - Pension Income
    - Unemployment Income
    - Copies of any 401K/403B/Other asset accounts (retirement savings)
    - Current balances in all Health Savings Accounts (HSA)
    - Copies of Certificates of Deposit (CD)

  For your financial security, please black out or white out any Social Security or bank account numbers prior to submitting documentations.

- ☐ If you are married you must also enclose the above information for your spouse.

It is the goal of the Financial Counselors to not only qualify you for Charity Care but also assist you with alternative coverage. If you do not cooperate with this process you may be denied for charity care.

You will continue to receive bills until we have your complete application. This includes the records listed above. If there are legal fees related to your account, Charity Care will not cover these fees.

All applications received will be processed within 30 business days from the date in which the completed application is received.

If you have any questions or are unable to return the forms on time, please call (218) 362-6624 or toll-free (877) 390-6624.

Fairview's Charity Care Application

Patient Information (include all family members applying for charity care)

	Name	Date of Birth	Medical Record Number (if available)
1			
2			
3			
4			
5			

Who can we contact about this application?
Name:_________________________Phone Numbers: (1)__________________(2)_________________
Address:__________________________City/State:_______________Zip Code:_________________
Family Size:_______________ (include spouse and dependent children)

Financial Information
Attach a copy of your most recent 1040 Federal Income Tax form. Also attach income records from the last two (2) pay stubs showing year to date gross income. List all sources of monthly income for your household.

Monthly Income

Earned Income:	$	Unemployment Income:	$
Pension/Retirement:	$	Social Security:	$
County/Government:	$	Child Support:	$
Other:	$		

Medical Assistance
Applied:_____________________ Date:______________________ County:_______________________
Denied: ☐ Yes ☐ No
Comments:
____
____

Assets (what you own)		Retirement Savings	
Checking Accounts:	$	Pension/Retirement:	$
Savings Accounts:	$	IRA:	$
Health Savings Accounts:	$	Other retirement investments:	$
Other:	$	Certificates of Deposit (CD):	$

The information above is true and correct to the best of my knowledge. If any details are false or incorrect, (Name of Organization) may stop any discounts I receive. (*All persons applying over the age of 18 must sign and date below.)*

*Signature*____ *Date*______________

Signature ____ *Date* ______________

Revised: 12/17