GLACIAL RIDGE
HEALTH SYSTEM

CHARITY CARE/FINANCIAL ASSISTANCE APPLICATION

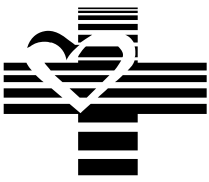
Name: First Middle Last		Spouse Name:	
Mailing Address:	City	State	Zip Code
Telephone #:	Cell Phone #:	# of dependents living with you:	
Employer:		Spouses Employer:	
Employer Address:		Spouses Employer Address:	
Employer Telephone #:		Spouses Employer Telephone #:	
Job Position:		Spouses Job Position:	

INCOME

List income for family from:	**Last 1 Month**	**Total for Last 12 Months**
Wages		
Farm or Self Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Worker's Compensation		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

ASSETS

Please provide the dollar value in:	**Last 1 Month**	**Total for Last 12 Months**
Savings Accounts		
Stocks, Bonds, CD's		
Property Owned – not residence		
Cash Value of Life Insurance Policies		
Other Investments		
Other Liquid Assets		



GLACIAL RIDGE
HEALTH SYSTEM

CHARITY CARE APPLICATION

EXPENSES

Please provide the dollar value in:	Last 1 Month	Total for Last 12 Months
House payment/Rent		
Property Taxes (if applicable)		
Utilities:		
Electric/Gas/Oil		
Telephone/Internet/Cable		
Water/Sewer/Garbage		
Insurance:		
Health		
Auto/Home		
Loan payments (personal, auto, etc.)		
Credit Cards		
Other Expenses (list)		

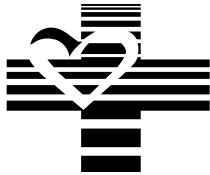
Other Documentation Required, if applicable:

- If you feel that your concerns have not been addressed, please contact 320-634-4521 first and allow us the opportunity to try to address your concerns. If you continue to have concerns that have not been addressed, you may contact the Minnesota Attorney General's Office by telephone at 651-296-3353 or 1-800-657-3787, by email at hospital.billing@AG.state.mn.us; or online at www.AG.state.mn.us/contact.
- **1040 Tax Return for most recent year**
- **W-2s for any W-2 Income listed on 1040**
- **Copies of the last 2 months of bank statements**
- **Most recent pay stub or statement of wages from all W-2 Employers**
- **Statement of disability or social security payments received**
- **Two months of recent invoices or statements relating to expenses claimed in the section above**

Glacial Ridge Health System requires thorough documentation from those applying for charity care discounts. Please make sure you have all documentation to support your claims in the sections above. Central to this is your inclusion of your most recent 1040 tax return. If you do not file income taxes, you should have some other government documentation of social security benefits or disability payments. This will normally be sufficient to establish your level of income.

Please fill out the attestation on the next page in order for us to process your application. We will do our best to process your application quickly and painlessly, but we often need to follow up with the applicants for more thorough documentation or information. We thank you in advance for your patience and cooperation.

Please return your completed application to Glacial Ridge Health System, 10 Fourth Avenue SE, Glenwood, MN 56334. Attn: Patient Account Rep



GLACIAL RIDGE
HEALTH SYSTEM

CHARITY CARE APPLICATION

I affirm the above information is true and correct to the best of my knowledge.

____________________________ ____________________________ ____________
Name (Person Completing Form) Signature (Person Completing Form) Date

Relation to Applicant, if not the Applicant: ____

Comments:____

For Office Use Only:

CEO/Administrator	**Date**
Chief Financial Officer	**Date**
Denied / Approved and Percentage Discount **Reasons:**	