Uncompensated Care Application

North Country
HEALTH SERVICES

The financial information you provide will enable North Country Health Services to determine the level and availability of financial assistance needed to resolve the balance of your account.

Patient Name:	SS#:	Birth Date:
Spouses Name:	SS#:	Birth Date:

Name and age of dependent(s) living in household, other than spouse:

Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:

Home Phone:	Alternate Phone:

Address:	City:	State:	ZIP:

Your Employer:	Spouses Employer:
Your Gross Monthly Income:	Spouses Gross Monthly Income:

Additional Income (Examples: social security, social security disability, workers' comp., rents, trusts, alimony, retirement income, dividends, child support, etc.):

Grand Total Income:

HOUSEHOLD EXPENSES:	
Housing/Rent Pymt:	
Vehicle Pymt(s):	
Food:	
Heat:	
Electricity:	
Water & Garbage:	
Telephone:	
Cell Phone:	
Daycare:	
Medical Insurance:	
Life Insurance:	
Auto Insurance:	
Homeowners Insurance:	
Clothing:	
School:	
Alimony/Child Support:	
Entertainment:	
Internet/Cable:	
Other (please specify):	
Total Monthly Expenses:	

Credit Card & Other Loans/Debts
(If you need additional space, attach a sheet of paper)

Lender	Current Balance	Monthly Payments

Grand Total Income:	
Total Monthly Expenses:	(-)
Difference:	

Have you applied for Medical Assistance through your county? Yes _____ No _____

County of residence: ______________________________________

Please take this form to the Department of Human Services in your county, bring your income verification and any bills that you have received. Ask your financial worker to complete the space below or give you written notification of your eligibility or non-eligibility for a medical assistance program.

FOR OFFICIAL USE ONLY:

______ A provisional analysis of the applicant's information indicates the possibility of medical financial assistance. An appointment has been set for ____________________________ (date).

Case number ________________ Effective as of ______________ (date)

______ Analysis of this applicant's information indicates that the applicant is not eligible for any medical assistance programs due to____.

______________________________________ ______________________________________

Signature of Case Worker Date

Assets:

Bank Information:

Checking Account Balance: _______________________ _______________________

Savings Account Balance: _______________________ _______________________

Do you: Own home _____ Rent home _____

I/we own the following motor vehicles:

Name of Owner(s)	Make	Model	Year

Additional assets: (Boats, motorcycles, snowmobiles, equipment, land, stocks, bonds, etc.)

Description	Estimated Value		Description	Estimated Value

I, __________________________________ certify that the above information was given in good faith and to the best of my knowledge is true and correct. I give my consent to have North Country Health Services verify the above information.

Please attach to this application:

( ) Income Tax Returns for previous two years

( ) Bank Statement (Checking, Saving, Other)

______________________________________ ______________________________________

Guarantor/Patient Signature Date

Revised: 09/2010