SANFORD HEALTH

Financial Assistance

Sanford Health is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance with our health system.

Enclosed with this letter, you will find a worksheet/application that demonstrates your financial condition. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Sanford Health, part or all of your account balance may be forgiven.

In order to process this application we require:

- **The enclosed application completed in its entirety and signed**
- **Proof of all income (i.e. Last two pay stubs for any wage earner contributing to household income, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement,Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, etc.)**
- **Copy of your most recent 1040 tax return, including all applicable schedules**
- **If your most recent tax return is not available, then we need one of the following:**
  - **Social Security Awards Letter**
  - **Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)**
- **Copy of your property tax assessment statement from county for any owned property**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or have any questions, please contact us at (877)629-2999. Our business hours are Monday - Thursday 7am - 6pm and Friday 7am - 5pm.

To Minnesota residents receiving service at Sanford Health facilities located in Minnesota: If you feel that your concerns have not been addressed, please contact Sanford's Patient Financial Services at (877)629-2999 first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at (651)296-3353 or (800)657-3787.

Please respond to this request for information within 30 days and return to our office by **SECURE FAX** at (800)544-5967 or **MAIL** to Sanford Health, PO Box 2010, Fargo, ND 58122-2482.

Thank you for your business.

Sincerely,

Sanford Health

SANFORD HEALTH

Accounts: _____

Date Sent: _____

Return By: _____

Return all applications to:

Sanford Health
PO Box 2010
Fargo, ND 58122-2482
(877) 629-2999
Secure Fax:
(800) 544-5967

Financial Assistance Application

Demographic Information

Name	Date of Birth	Spouse	Date of Birth

Address	City	State	Zip

Time at Present Address: ____ Years ____ Months	County	Marital Status
__ Rent __ Own		__ Married __ Single __ Divorced __ Widowed

Cell Phone Number	Work Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number

Please list ALL dependents living in your household: (Attach an additional sheet if needed)

Last Name	First Name	MI	Date of Birth	Social Security #	Relationship to Applicant
1.					
2.					
3.					
4.					

	Self		Spouse		
Social Security #			Social Security #		
Employed By			Employed By		
Business Address			Business Address		
Occupation		Hourly Wage	Occupation		Hourly Wage
How Long Employed: ___ Years ___ Months		___ Hours Worked Per Week	How Long Employed: ___ Years ___ Months		___ Hours Worked Per Week

Additional Information

Have you ever declared bankruptcy? ___ No ___ Yes ___ Chapter 7 ___ Chapter 13 Date Filed: _____ Date of Discharge: _____

Do you have any judgments or liens filed against you? If yes, please provide date and reason: _____

	Applicant Primary Insurance Coverage	Secondary Insurance Coverage	Spouse Primary Insurance Coverage	Secondary Insurance Coverage
Name:				
Address:				
Subscriber:				
ID & Group #:				

Source Of Income

Income: Represents total cash receipts from all sources before taxes.

	Self Monthly Gross		Spouse Monthly Gross
Gross Income		Gross Income	
Social Security / SSI / SSDI		Social Security / SSI / SSDI	
Public Assistance		Public Assistance	
Rental Income		Rental Income	
Retirement/Pension		Retirement/Pension	
Veterans Benefits		Veterans Benefits	
Unemployment / Work Comp From: To:		Unemployment / Work Comp From: To:	
Child Support / Alimony From: To:		Child Support / Alimony From: To:	
Other Please Identify:		Other Please Identify:	
TOTAL		**TOTAL**	

Combined Monthly Gross Income:

Assets

	Location	Amt/Value		Location	Amt/Value
Checking			Certificate of Deposit (CD)		
Savings			Stocks/Bonds		
Other			Other		

Assets / Property

Motor Vehicle	Year / Make / Model	Value	Loan Balance	Lien Holder
	Year / Make / Model	Value	Loan Balance	Lien Holder
Recreational Equipment (boats, snowmobiles, etc.)	Year / Make / Model	Value	Loan Balance	Lien Holder
	Year / Make / Model	Value	Loan Balance	Lien Holder

Other Property	Address, Township, County	Loan Balance	Assessed Value
	Address, Township, County	Loan Balance	Assessed Value
Homestead	Address		Assessed Value
	Township, County	Mortgage Balance	Lien Holder

Monthly Expenses

House Payment / Rent	Water and Sewer	Auto Insurance	Life Insurance
Property Taxes	Phone/Cell Phone	Food	Health Insurance
Property Insurance	Cable TV	Daycare Expense	Medications
Heat	Vehicle Payment	Child Support Expense	Other/Specify
Electric	Transportation Expense	Recreational Equipment	TOTAL

Credit Cards/Other Expenses

Creditor Name	Address	Balance	Monthly Payment
		TOTAL	
		GRAND TOTAL / CREDIT CARDS, OTHER EXPENSES AND MONTHLY EXPENSES	

How much of your Sanford bill are you paying/or are able to pay per month? _____

REQUIRED DOCUMENTS:

__ Proof of all income: (i.e. 2 paystubs for each wage earner, SS, SSI, SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony, or Other).

__ Copy of your most recent 1040 tax return, including all applicable schedules.

__ Copy of your property tax assessment statement from county for all owned property.

ASSIGNMENT OF RIGHTS (Please Read Carefully)

By signing below I certify that the information and statements contained in this Application for Financial Assistance and the documentation which I submit are accurate, true and correct to the best of my knowledge.

I understand that Sanford Health may make reasonable requests for additional information and verification if necessary.

I understand that the information and statements I have provided will be kept confidential by Sanford Health.

I understand that the completion of this application will allow Sanford Health to consider my circumstances.

I understand Sanford Health makes no representations that financial assistance is guaranteed.

I/We hereby certify the above information is correct and voluntarily authorize you to obtain credit information relative to me/us.

Signature _____ Date _____ Signature _____ Date _____