

UNINSURED/COMMUNITY CARE APPLICATION INSTRUCTIONS

1. Fill out the application completely, do not skip categories.
2. Provide COMPLETE DOCUMENTATION as requested in the application.
3. If you are applying for Community Care it is our policy that you apply for Medical Assistance (see Credit Policy & Financial assistance options at WestHealth).
4. Mail the application to:

WestHealth, Inc.
Attn: Julie Frosch
2855 Campus Drive
Suite 465
Plymouth, MN 55441

Please contact Julie at (763) 577-7141 if you have any questions or concerns regarding completion of this application.



WESTHEALTH
outpatient health care

2855 & 2805 campus drive
plymouth, MN 55441
phone 763-577-7000

UNINSURED/COMMUNITY CARE FINANCIAL APPLICATION

1. Patient(s) name: _____ D.O.B. _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Responsible Party _____ D.O.B. _____ Social Sec. # _____

Street Address _____ City _____ State _____ Zip Code _____

Marital Status M D S W

Place of Employment _____

Information Re: Spouse of Responsible Party: Name _____

D.O.B. _____ Social Sec. # _____

Place of Employment _____

2. Financial Assistance Requested for:

Account Number (s)	Original Charges	Current Balance	Monthly Payments

3. Persons living at home that you are financially responsible for:

Name	Relationship	Age

4. Source(s) of Income (All Family Members):

	Total Income Earned For Last 3 Months	Total Income Earned for Last 12 Months
Wages: Gross Income	\$	\$
Farm or Self-Employment		
Social Security		
Workers Compensation		
Alimony		
Child Support		
Dividends/Interest/Rental Income		
Unemployment Compensation		
Pension		
Other:		
Total Income	\$	\$

5. Are eligible for medical assistance now? Yes No

Were you eligible for medical assistance for the dates of service for which you are applying for financial assistance? Yes No

Did you apply for county medical assistance for time period you requested financial assistance? Yes No

If yes, what is the effective date? _____

If no, please attach a statement explaining the reason you did not apply.

6. Please return a copy of most recent Federal and State Income tax returns & most recent payroll stub (include copy of W2).

7. I affirm that the information provided above is true, accurate and complete to the best of my knowledge. I agree to notify WestHealth, Inc., of any changes in my financial status until this application has been processed by WestHealth. I understand that failure to do so, and/or misrepresentation of the information on this application may result in the account(s) being reactivated and placed with a third party for collection.

Signature (person making request)

Date

MINNESOTA HEALTHCARE
PROGRAMS 2008

CALL YOUR COUNTY HUMAN OR
SOCIAL SERVICES OFFICE

OR

MINNESOTA CARE AT (651) 297-3862
OR (800) 657-3672. THE TOLL- FREE NUMBER
IS ONLY AVAILABLE TO INDIVIDUALS THAT NEED
TO CALL LONG DISTANCE TO REACH
MINNESOTA CARE.

OR

www.dhs.state.mn.us/healthcare