



## 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 and following documentation to:

Bank statements (last 3 months)  
Denial from MN Medical Assistance if available  
Pay stubs (last 3 months)  
Copy of your Federal tax return  
W2  
Completed Application

WestHealth, Inc.  
Attn: Naomi Weston  
2855 Campus Drive  
Suite 465  
Plymouth, MN 55441

Please contact Naomi at (763) 577-7081 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