Community Care Program Application

Applicant/Responsible Party: _____ _____ _____
Last Name First Name MI

Patient Name: _____ _____ _____
(If different than applicant) Last Name First Name MI

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Email Address:
_____

U.S. Citizen: □ Yes □ No Marital Status: □ Single □ Married □ Widowed □ Divorced

Was Medical Assistance denied? □ Yes □ No
Is Applicant ineligible for Medical Assistance? □ Yes □ No

If you answered YES to either of the above questions, please state reason why: _____
♦ Attach a copy of your denial letter with this application if you received

Complete information below for each household member (Include the applicant):

Name	Relation to Applicant	Date of Birth	Health Ins. Coverage/Company	Student Yes/No	Employed Yes/No

Income Information

A. Employment Information

Applicant Social Security #: _____ Employer: _____

Spouse Social Security #: _____Employer: _____

Can someone else claim you as a dependent for tax purposes: □ Yes □ No

B. Income Information by Month

Monthly Income Source	Applicant	Spouse/Household Member	Household Member Exclude income from children 17 & under
Salaries, Wages & tips			
Interest Income			
Social Security/SSI			
Disability			
Unemployment Compensation			
Worker's Compensation			
Pension(s)			
Alimony			
Rental Income			
Public Assistance			
Military Income			
Other:			

If Self-Employed:

Gross Income: $_____ minus Expenses: $_____

♦ Attach copies of the following documents for all household members:
- ♦ Copy of last year's tax return for each adult household member
- ♦ Proof of income claimed above if other than regular wages

♦ If tax return in unavailable/not completed, the following will be required:
- ♦ Copies of paycheck stubs for the past three (3) months or a written statement from employer(s) showing earnings
  For past three (3) months.
- ♦ Proof of income claimed above if other than regular wages

I understand that the information provided is subject to verification. I certify that the information on this application is true and correct to the best of my knowledge. I agree to notify North Shore Health promptly of any changes to the information in this document.

Applicant's Signature:

_____

Date: _____

Please return this application and supportive documents to: North Shore Health
Attn: Business Office
515 5th Ave. West
Grand Marais, MN 55604

Questions: Call 218-387-3040