



## 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 first two(2) pages of last year's tax return for each adult household member (ie Fed tax form 1040, 1040E)
  - ◆ Proof of Income, including; copies of paycheck stubs for the past three (3) months for each household member 18 & older, social security benefit letter, unemployment benefits or work comp benefits.
  - ◆ Medical Assistance denial notification, if applicable
- ◆ If tax return in unavailable/not completed, the following will be required:
  - ◆ Proof of Income, including; copies of paycheck stubs for the past three (3) months for each household member 18 & older, social security benefit letter, unemployment benefits or work comp benefits.
  - ◆ Copies of **complete** bank statements for past three (3) months for each adult household member
  - ◆ W-2's

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 5<sup>th</sup> Ave. West  
Grand Marais, MN 55604**

**Questions: Call 218-387-3040**