FINANCIAL ASSISTANCE APPLICATION

Langdon Prairie HEALTH

Langdon Prairie Health's Financial Assistance Policy requires an individual to complete the following prior to an application for financial assistance being processed.

1. Could you possibly qualify for Medicaid? (Coverage is available to all qualifying low-income adults under age 65)
☐ Yes ☐ No **If Yes**, complete steps #2 and #3. **If No**, skip to #3.

2. Apply for medical assistance (Medicaid) within the time frame (generally 3 months within the date of service) required by the county office.

3. Attach a copy of the following (REQUIRED):
- ☐ Medical Assistance Determination
- ☐ Healthy Steps Determination (if applicable)
- ☐ Most current Federal Income Tax return
- ☐ Check stubs or bank statements from the last 3 months of income

Date application sent to Langdon Prairie Health: _____

Guarantor's Name: _____

Address: _____

City: _____ State _____ Zip _____

Account # _____ Balance Due _____

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Dependent Information: (as claimed on the Federal Tax return)

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Guarantor Information:

Employer: _____ Telephone Number: _____
Length of Employment: _____ Current Position _____
Gross Salary: $_____ Average Number of Hours Worked per Week: _____

Spouse Information:

Employer: _____ Telephone Number: _____
Length of Employment: _____ Current Position _____
Gross Salary: $_____ Average Number of Hours Worked per Week: _____

Other Sources of Income: (include spouse's other income)

Social Security: $_____ per ☐ month ☐ year

Pension $_____ per ☐ month ☐ year

Railroad Retirement $_____ per ☐ month ☐ year

Workers Compensation $_____ per ☐ month ☐ year

Unemployment $_____ per ☐ month ☐ year

Rental Property Income$_____ per ☐ month ☐ year

Child Support/Alimony $_____ per ☐ month ☐ year

Interest/Dividends $_____ per ☐ month ☐ year

Tax Refund $_____ per ☐ month ☐ year

Other $_____ per ☐ month ☐ year

Total Annual Household Gross Income: $_____

Total Household Gross Income in last 3 months: $_____

Please note: LPH cannot process your application without verifiable proof of household income.
Questions? Please call our Business Office at 701-256-6100 or our CFO at 701-256-6172.

I hereby request Langdon Prairie Health services be provided to me or my family member without charge or at a reduced charge as determined according to Federal Poverty Guidelines. In requesting financial assistance, I represent that I am unable to pay for the health care services requested or provided and all the information supplied by me in this application is complete and accurate. I understand that the information which I have submitted on this application is subject to verification. I do hereby release Langdon Prairie Health and their respective agents and employees from all liability arising out of their reasonable efforts to verify information I have stated in this application.

I understand that if I do not make payments on my account and it goes into collections. Any discount I received from Financial Assistance will be reversed and the full balance prior to Financial Assistance will be collected by the collection agency.

Signed: _____ Date: _____

SUBMIT

For Office Use Only

Control Number: _____ Date Application Received: _____

Determination:

_____ Eligible for _____% Write Off to Charity

_____ Denied: Incomplete Application

_____ Denied: Verified Household Income over Federal Income Guidelines

Charity Care Write Off: _____ Balance Remaining: $_____

Determination Made by: _____ Date: _____

Title: _____