Tri-County Health Care

Uncompensated Care Application

I hereby request that Tri-County Health Care make a determination of eligibility for uncompensated services. I understand that the information that I submit for my annual income, family size and assets is subject to verification by Tri-County Health Care. I also understand that if the information I submit is determined to be false, such a determination will result in a denial of providing uncompensated services and that I will be liable for the charges for services provided.

Name:	
Birthdate:	SS#:
Address:	
City/State/ZIP:	
Phone:	
Employer:	

Spouse:	
Spouse Birthdate:	SS#:
Spouse Phone:	
Spouse Employer:	

***TOTAL FAMILY SIZE:**

List Below All Members of Household Beginning with Patient					
Name	Age	Birthdate	Name	Age	Birthdate

*Family size of one is denoted as a person 15 years of age or older who is not living with any relatives. Family units of size greater than one include only persons related by birth, marriage or adoption, who reside together. Students younger than age 26, regardless of residence who are supported by parents or others related by blood, marriage or adoption are considered to be residing with those who support them. One hundred percent forgiveness is obtained at 200 percent of the 2021 Federal Poverty Guidelines.

FAMILY SIZE	ANNUAL INCOME GUIDELINES
1	$25,760
2	$34,840
3	$43,920
4	$53,000
5	$62,080
6	$71,160
7	$80,240
8	$89,320

For family units with more than eight members, add $4,420 for each additional member.

	Patient	**Spouse**	**Other**
Wages (Gross)	$	$	$
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List…			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME: $	MONTHLY: $	YEARLY: $	

Tri-County Health Care

EXPENSES	MONTHLY		HOUSEHOLD ASSETS		VALUE
Mortgage or Rent Payment	$		Savings (attach copy)		$
Auto (Ins, Gas, payment)			Checking (attach copy)		
Utilities (Gas, Electric, Water)			Stocks and Bonds		
Cable			Mutual funds, Money Market, etc.		
Phone (including Cell)			Cash Value of Life Insurance		
Food			Real Estate Value (non-homestead)		
Child Care			Vehicles Value (not including primary)		
Clothing			Jewelry & Other Personal Property		
Insurance (Medical, Dental, Vision, Homeowners, Rental)			Other Assets (Describe)		
Gas/Transportation					
Recreation					
Physicians					
Hospitals					
Other Medical					
Credit Cards					
Other Expenses (describe)			**Total Household Assets:**		$
			Household Debts	**Payment**	**Balance**
			Home Loan	$	$
			Auto Loan	$	$
			Credit Card Debt	$	$
			Other:	$	$
Total Expenses:	$		Total Household Debts:	$	$

Other Pertinent Information Regarding Financial Situation

*Assets are not considered for forgiveness of clinic balances and can be skipped if applying for clinic bills only. (Assets are not considered for NHSC Program.)

Medical Assistance

County applied _____ Date applied _____

Approved/Denied _____ Copy of letter attached ☐ Yes ☐ No

I understand that the information that I submit is subject to verification by Tri-County Health Care and subject to review and final determination by the Uncompensated Care Committee within 60 days of satisfactory completion/application. I certify that the information submitted is true and correct:

SIGNATURE:	**DATE:**

TCHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
TCHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

Tri-County Health Care

Uncompensated Care Application Checklist

As Part of the Uncompensated Care Application process we will need you to send information to verify your income and assets as it applies to your household.

The following information is required and must be included with your completed application. The application should be returned within 30 days.

Federal and State Tax Return	Did you file taxes last year?	☐ Yes ☐ No	If Yes, include your current tax return.
Employment Income	Is anyone in your household employed?	☐ Yes ☐ No	If Yes, send the last 3 months of paystubs for all employed household members.
Unemployment Income	Is anyone in your household receiving unemployment income?	☐ Yes ☐ No	If Yes, send the current unemployment award letter.
Social Security/ Disability Income	Is anyone in your household receiving Social Security/Disability income?	☐ Yes ☐ No	If Yes, send the current award letter.
Child Support/Alimony	Does anyone in your household receive Child Support or Alimony payments?	☐ Yes ☐ No	If Yes, send proof of deposits.
Bank Accounts	Does anyone in your household have a checking or savings account?	☐ Yes ☐ No	If Yes, send current statements for all bank accounts.
Investments	Does anyone in your household have investments? (stocks, bonds, mutual funds, money markets)	☐ Yes ☐ No	If Yes, send current investment statements.
Non-Homesteaded Property	Does anyone in your household own any non-homesteaded property?	☐ Yes ☐ No	If Yes, send current property tax statement for all non-homesteaded property
MA/MNCare	Have you applied for MA or MNCare with your county of residence?	☐ Yes ☐ No	As part of our application process you will need to apply if you have not. Please send proof of your county's determination.
Life Insurance	Does anyone in your household have life insurance that has a cash value?	☐ Yes ☐ No	If Yes, send current statement showing value.

*Please remember to sign and date the application. If you have any questions or need help filling out the application please contact us.

Thank you,

Patient Resource Department, Phone: 218-631-7498, Email: CCR@tchc.org, Fax: 218-631-7595