PHYSICIANS
UNIVERSITY OF MINNESOTA

Patient Financial Services
720 Washington Ave SE
Suite 200
Minneapolis, MN 55414

Dear Patient,

Enclosed is an application for the University of Minnesota Physicians Community Care program. This is a discount program to assist you with paying for medically necessary care that you need to maintain your health. It applies to services billed by University of Minnesota Physicians only.

It does not apply towards care that is considered elective, cosmetic or any MHealth or MHealth Fairview fees.

To apply, please send the following information along with the completed application:

1. Copy of your current 1040 Federal Income Tax form.
2. Copy of all nontaxable income received last year, such as: Social Security, Child Support, Workers Compensation, Unemployment or Disability payments
3. Copies of bank statements for all checking and savings accounts for the past 90 days, including the last statement for any CD's (certificate of deposits).
4. Records of all retirement savings, employment pension plans, 401K 401A, 403B plans, annuities, IRA's.
5. Copies of your health insurance cards.
6. You ***may*** be required to provide a written response from your county to verify if you were approved or denied Medical Assistance.

This completed application along with copies of the listed information must be returned within 30 days of the date of this letter. Call us at 763-782-6507 or toll free 1-833-914-1046 if you cannot return the forms before this date.

Without all of the required information, you may not qualify for the program.

Thank you for choosing the University of Minnesota Physicians for your healthcare needs. It is our privilege and pleasure to care for you.

University of Minnesota Physicians – Community Care Application

Patient Information (include all family members applying for community care)

Patient Name: Date of Birth: Medical Record Number:

Patient Name	Date of Birth	Medical Record Number
1.		
2.		
3.		
4.		
5.		

Contact person for this application:

Name:_____ Phone #:____-____-_____Social Security #:____-___-_____

Address:_____ City/State/Zip Code:_____

Family Size:_____(include all persons who live with you. This should be the same as on your tax return).

Medical Assistance Programs/Insurance Information:

Attach a copy of the written response from your county showing if you have been approved or denied for MN Medical Assistance programs.

Date applied for Assistance:_____ County of application:_____Were you approved Y/N:___

Case Worker's Name:_____ __ Case Worker's Phone #:_____

Do you have Health Insurance coverage (Yes/No):____ If yes, please submit a copy of your insurance card(s).

Financial Information:

Attach the following items along with this form. We will keep your financial records confidential.

1. A copy of your most recent 1040 Federal Income Tax form.

2. A copy of all Nontaxable Income Statements for last year: Social Security, Child Support, Workers Compensation, Unemployment, or Disability payments.

3. Copies of bank statements for all checking and savings accounts for the past 90 days. Including the last statement for any CD's (certificate of deposits).

4. Records of all retirement savings, employee pension plans, 401K, 401A, 403B plans, annuities, IRA's.

The information submitted is complete and correct to the best of my knowledge. Please sign and date below:

Signature:_____ Date:_____