



SARTELL
804 23rd Street South, Sartell, MN 56377
Office: 320-230-7788 ** Fax: 320-230-7789

BAXTER
15620 Edgewood Drive, Suite 200, Baxter, MN 56401
Office: 218-270-3111 ** 218-270-3204

ALEXANDRIA
519 22nd Avenue East, Alexandria, MN 56308
Office: 320-219-7611 ** 320-219-7612
www.centerforpainmanagement.org

Dear ,

Center for Pain Management Financial Assistance Program was established to assist patients who do not have the ability to pay for service rendered. If a patient meets the guidelines, the total bill or a portion of the charges may be covered. To be considered for assistance, please fill out the application form completely, sign and return with the requested information below.

Please include a copy of the following with your Hardship Application:

- Your most recent Federal income tax return, including all schedules
- Your most recent State income tax return, including all schedules
- Any denial letters from Social Security Disability (if applicable)
- Any denial letters from Medical Assistance (if applicable, if the necessary information we need is contained within this denial letter, an application may not be necessary, please see the Business Office for more information)

Please be sure the application is signed by all financially responsible parties within the household, before sending it in.

If you have any questions, difficulty in completing the Hardship Application, or problems in obtaining the required accompanying documentation, be sure to contact our Billing Office at 320-281-5288.

Please fill this out and we may be able to forgive some of your balance.



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Patient Financial Assistance

Patient Name		Patient's Employer Name, Address, Phone #, Length of Employment & Job Title
DOB	SS #	
Address		
City/State/Zip		
Home #	Cell #	Spouse's Employer Name, Address, Phone #, Length of Employment & Job Title
Marital Status		
Responsible Party		
Spouse's Name		Special Circumstances / Notes
DOB	SS #	
Does someone else claim you as a dependent? If yes, who?		

Household Information

Member #1 (name, relationship, age, occupation)	Member #4 (name, relationship, age, occupation)
Member #2 (name, relationship, age, occupation)	Member #5 (name, relationship, age, occupation)
Member #3 (name, relationship, age, occupation)	Member #6 (name, relationship, age, occupation)

Assett & Banking Info

Bank Name		Patient's Contribution to Retirement
Checking Acct #	Checking Balance	Spouse's Contribution to Retirement
Savings Acct #	Savings Balance	Other Investments & Securities (Stocks, Bonds, CD's, etc)

Household Financial Information

After Tax Monthly Total Household Income	Source	Amount
Patient		\$
Spouse / Responsible Party		\$
Interest / Dividends		\$
Unemployment		\$
Social Security, SSI, Railroad Retirement		\$
Scholarships, Fellowships, Grants & non-Taxable Military Compensation or Cash Benefits		\$
Pensions & Annuities, including IRA, Keogh, & SEP Distributions		\$
Workers Compensation, Income Continuation & Loss of Time Insurance		\$
Support Money & Maintenance Payments (court ordered)		\$
Rental Property		\$
Total Net Monthly Income		\$

Assets	Estimated Value	Unpaid Balance	Monthly Payment
Vehicle year/make	\$	\$	\$
Vehicle year/make	\$	\$	\$
Recreation vehicles (boats, campers, ATV's)	\$	\$	\$
Land # Acres (excluding residence)	\$	\$	\$
Business	\$	\$	\$
Rental Property	\$	\$	\$
Other	\$	\$	\$

Monthly Expenses (please indicate your average monthly expenses for each item)	Monthly Payment
Residence (please circle one) RENT OWN	\$
Groceries	\$
Utilities (water, sewer, electric, gas, etc)	\$
Vehicle (gas, repairs)	\$
Cell Phone and/or Landline	\$
Internet	\$
Cable/Satellite	\$
Child Care	\$
Child Support	\$
Auto Insurance	\$
Life Insurance (if deducted from your paycheck, do not include a separate line)	\$
Health Insurance (if deducted from your paycheck, do not include a separate line)	\$
Other Insurance (if deducted from your paycheck, do not include a separate line)	\$
Medications	\$
Personal Essentials (not included in groceries, such as clothing, diapers, toiletries, etc) Describe:	\$
Other – Describe:	\$

Creditors (please list all)	To Whom	Original Principal Amount	Unpaid Balance	Monthly Payment
Medical Expense #1		\$	\$	\$
Medical Expense #2		\$	\$	\$
Medical Expense #3		\$	\$	\$
Credit Card #1		\$	\$	\$
Credit Card #2		\$	\$	\$
Credit Card #3		\$	\$	\$
Student Loan #1		\$	\$	\$
Student Loan #2		\$	\$	\$
Student Loan #2		\$	\$	\$
Student Loan #3		\$	\$	\$
Personal, Quick Cash or Other Loan/s #1		\$	\$	\$
Personal, Quick Cash or Other Loan/s #2		\$	\$	\$

Complete and return this **Financial Assistance Application**, along with a copy of last year's State and Federal tax return, bank statement, and a copy of your pay stubs showing income for the past 60 days.

This information is required in order to process your application. Credit Bureau reports may be requested to assist in determining ability to pay medical bills.

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I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by The Center for Pain Management. I hereby grant permission to The Center for Pain Management to investigate the information contained herein.

Patient Signature (if over 18) _____
Date

Responsible Party (if minor) _____
Date
Or Spouse Signature (if over 18 and married)

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The Center for Pain Management Billing Office reviewed this application and the following determination was made:

_____ This application has been approved for a discount of _____%. This equates to the \$_____ being written off.

_____ This application has been denied for a discount and any waiver of fees. The applicant/s doesn't meet the financial hardship criteria of the clinic.

_____ Payment arrangement options were discussed with the applicant/s.

_____ The applicant has been advised to apply for MA, retroactively three (3) months.

_____ The applicant/s have been notified of our decision on _____ (date) via:
(circle one) Phone Email Letter

Billing Office Staff Signature _____
Date

Management Signature _____
Date