Caribou MEDICAL CENTER

300 South 3rd West
Soda Springs, ID 83276
(208) 547-3341

Financial Assistance Application Form

Patient Name: _____

Account #(s): _____ _____ _____

GUARANTOR

(if patient is a minor, use father's information)

Name: _____ SSN: _____

Address: _____ DOB: _____ Marital Status: _____

City, State, Zip: _____ Years at Residence: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Previous Address: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Previous Employer: _____ Prev. Employer Phone: _____

Prev. Employer Address: _____

DEPENDENTS

Name	DOB:	SSN	Living in Household?

SPOUSE

(if patient is a minor, use mother's information)

Name: _____ SSN: _____

Address: _____ DOB: _____ Marital Status: _____

City, State, Zip: _____ Years at Residence: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Previous Address: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Previous Employer: _____ Prev. Employer Phone: _____

Prev. Employer Address: _____

FINANCIAL INFORMATION
(include ALL household income)

Household Gross Income: _____ Monthly Take-Home Income: _____ Other Income: _____

Social Security: _____ Retirement/Pension: _____ IRA: _____

CD: _____ Stocks/Bonds/Annuities: _____ Welfare: _____ Food Stamps: _____

Home: ☐ Own ☐ Rent Monthly Payment: _____

Paid To: _____ Property Value: _____ Balance Owed: _____

VEHICLES

Year/Make/Model	Monthly Payment	Balance Owed:	Paid To:

RECREATIONAL VEHICLES

Year/Make/Model	Monthly Payment	Balance Owed:	Paid To:

MONTHLY EXPENSES

Expense	Current	Past Due		Expense	Current	Past Due
Rent or Mortgage:				Child Care:		
Power:				Phone:		
Gas/Oil Heat:				Gasoline:		
Water/Sewer/Trash:				Groceries:		
Auto Payments:				Health Insurance:		
Auto Insurance:				Life Insurance:		
Medications:				Fines/Garnishments:		
Child Support:				Other:		

MEDICAL BILLS, CREDIT CARDS, LOANS, & OTHER DEBTS

Name	Address, City, State, Zip	Balance Owed	Monthly Payment

RELEASE OF INFORMATION

I do hereby authorize and direct any hospital or physician who has attended to me, any and all Idaho county entities, the State of Idaho Department of Health and Welfare, all federal government agencies (i.e., Social Security Administration, Veterans Administration) and all creditors, banks, and lending institutions to release any and all information they may have pertaining to me and any member of my family to Caribou Medical Center to obtain my credit report to verify all financial information. This information include but is not limited to application, decisions, records, medical and otherwise, reports, bills, and invoices. A photocopy of this authorization may be used in lieu of the original.

APPLICANT MUST PROVIDE THE FOLLOWING

(if document does not apply, write "NA".)

- ☐ Two most recent pay stubs for each wage earner
- ☐ Last year's federal tax return for each person that filed
- ☐ Child Support (if applicable)
- ☐ Alimony (if applicable)
- ☐ Social Security Income Statement (if applicable)
- ☐ Unemployment Compensation Letter (if applicable)
- ☐ Other source of income (if listed on first page)
- ☐ Proof of residency (i.e., a gas, electric, phone, or cable bill, rent receipt, credit card bill, voter registration, or driver's license

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Print Name _____ Date _____

Signature _____

If you have questions, please call (208) 547-3341 and ask for a financial counselor

When complete, please mail to:
Caribou Medical Center
300 South 3rd West
Soda Springs, ID 83276

or

When complete, please return to:
Physician's office or front desk
at Caribou Medical Center