Caribou MEDICAL CENTER

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

Financial Assistance Application

Patient Name: _____

Account #(s): _____ _____ _____

GUARANTOR
(if patient is a minor, use responsible party's information)

Name: _____ DOB: _____
Address: _____ Marital Status: _____
City, State, Zip: _____ Yrs. at Residence: _____
Home Phone: _____ Mobile: _____ Work Phone: _____
Employer: _____ Employer Phone: _____
Employer Address: _____ Hourly Wage: _____

SPOUSE/SIGNIFICANT OTHER/PARTNER
(if patient is a minor, use responsible party's information)

Name: _____ DOB: _____
Address: _____ Marital Status: _____
City, State, Zip: _____ Yrs. at Residence: _____
Home Phone: _____ Mobile: _____ Work Phone: _____
Employer: _____ Employer Phone: _____
Employer Address: _____ Hourly Wage: _____

DEPENDENTS/HOUSEHOLD MEMBERS

Title/Relation	Name	DOB
Guarantor/Self		
Spouse/Partner		
Child		
Child		
Child		
Child		
Child		
Child		
Other		
Other		

FINANCIAL INFORMATION
(include ALL household income: Guarantor, Spouse/Partner/Other)

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

Social Security: _____ Retirement/Pension: _____

Welfare: _____ Food Stamps: _____

Other: _____

INVESTMENTS & ASSETS

CD's: _____ Stocks/Bonds/Annuities: _____ IRA: _____

Home: ☐ Own ☐ Rent Monthly Payment: _____

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

VEHICLES/ATV/UTV/ CYCLES/SLEDS

Year/Make/Model	Monthly Payment	Balance owed	Paid to

MONTHLY EXPENSES

Expense	Current	Past Due
Rent or Mortgage		
Power		
Gas/Oil Heat		
Water/Sewer/Trash		
Auto Payments		
Auto Insurance		
Medications		
Child Support		

Expense	Current	Past Due
Child Care		
Phone		
Gasoline		
Groceries		
Health Insurance		
Live Insurance		
Fines/Garnishments		
Other		

MEDICAL BILLS, CREDIT CARDS, LOANS & OTHER DEBTS

Name	Balanced Owed	Monthly Payment

APPLICANT MUST PROVIDE THE FOLLOWING
(if document does not apply, write "NA")

- ☐ Two most recent pay stubs for wage earners
  and/or
- ☐ Last year's federal tax return for each person that filed
- ☐ Child Support (if applicable)
- ☐ Social Security Income Statement (if applicable)
- ☐ Unemployment Compensation Letter (if applicable)
- ☐ Other source of income (if listed on second page)

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

For Administrative Use Only

Recommendation/Explanation: _____

_____

_____

_____

Balance: _____ Approval/Denial Date: _____

☐ Denial ☐ Approval

% Write Off	***And Or***	Write Off Amount

Reason for Committee Decision: _____

_____

_____

_____
Signature Director of Revenue Cycle

_____ _____
Signature CEO Signature CFO