Fairview Community Care Application

Print, complete and mail completed application along with a status of your Medical Assistance application to: Fairview Health Services, Community Care, 400 Stinson Blvd. NE, Minneapolis, MN 55413

Patient Information

Name _____Account Number(s)_____

Please List the Name and Date of Birth For Other Family Members Applying

_____ _____

_____ _____

Date of Service (received or anticipated): From_____ To_____

Person Responsible for Account:

Name_____ Phone Number (H)_____(W)_____

Address_____ City/State_____ Zip Code _____

Family Size _____ (include all persons living at your residence)

Financial Information

Family Income (most recent 12 months before taxes)

Is anyone in your household employed? Yes No

Please list all household monthly income sources. Provide copies of your current 1040 Federal Income Tax form along with documentation of your current income: pay stub, unemployment, or social security .

List Employers	**Income From Each Employer**
1. _____	$_____
2. _____	$_____

Unemployment Income: _____ Social Security: _____

Pension/Retirement: _____ Child Support: _____

County/Government: _____ Other: _____

Assets (what you own)

Cash/Bank Balances:

Checking Account(s) $ _____

Savings Account(s) $ _____

Savings and Investments (non-retirement):

_____ $ _____

_____ $ _____

Secondary Property (excluding primary residence):

$ _____

$ _____

Property:

Auto $ _____

Other $ _____

I certify that the information provided is true and correct to the best of my knowledge and belief and that any false representations of misinformation can be cause to invalidate any discounts allowed by the facility. All persons applying over the age of 18 must sign and date below.

Signature _____ Date _____

Signature _____ Date _____