NHSC Financial Assistance

Sanford Health is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance with our health system.

Enclosed with this letter, you will find an application that demonstrates your financial situation. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Sanford Health, part or all your account balance may be forgiven.

In addition to a completed application, please provide the following:

- **Copy of your most recent Federal 1040 tax return, including all applicable schedules OR Proof of non-filing from the IRS (go to the IRS website at www.irs.gov)**

  AND ONE OF THE FOLLOWING:

- **Copy of last two pay stubs for any wage earner contributing to household income**
- **Social Security Awards Letter or most recent 1099 if receiving Social Security (If you are receiving Social Security as well as have other income, please provide proof of additional income)**

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation along with any pertinent changes.

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If your financial situation has changed since you submitted your original application, you can submit an appeal within 30 days of the date on your determination letter. If you wish to discuss your account, have any questions or would like to inquire about an appeal, please contact Sanford Patient Financial Services at (877)629-2999. Our business hours are Monday – Thursday 7am – 6pm and Friday 7am – 5pm.

To Minnesota residents receiving service at Sanford Health facilities located in Minnesota: If you feel that your concerns have not been addressed, please contact Sanford's Patient Financial Services at (877)629-2999 first and allow us the opportunity to try and address your concerns. If you continue to have concerns that have not been addressed, you may contact the MN Attorney General's Office at (651)296-3353 or (800)657-3787.

Please respond to this request for information within 30 days and return to our office by **SECURE FAX** at (800)544-5967 or **MAIL** to Sanford Health, PO Box 2010, Fargo, ND 58122-2482.

Thank you for your business.

Sincerely,

Sanford Health

SANFORD HEALTH

Submit application to:
Sanford Health
PO Box 2010
Fargo, ND 58122-2482
OR
Secure Fax: 800-544-5967

NHSC Financial Assistance Application

Demographics

Name: _____ Date of Birth: _____
Spouse's Name: _____ Date of Birth: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone (Self): _____ Cell Phone (Spouse): _____ Home Phone Number: _____

Please, list all dependents under the age of 18 living in your household

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Income

Self	Monthly Gross Income	Spouse
$	Gross Income/Unemployment/Work Comp	$
$	Social Security/SSI/SSDI	$
$	Self-employment/Rental Income/Royalties/Estates/Trusts	$
$	Retirement/Pension/Annuities/Veteran's Benefits	$
$	Child Support/Spousal Support/Public Assistance	$
$	Miscellaneous/Other Income: _____	$
$	**Total Income (Please provide proof of all income)**	**$**

How much of your Sanford bill are you paying/or can pay per month? _____

Assignment of Rights (Please Read Carefully)

By signing below, I certify that the information on this application and the supporting documentation are true and correct to the best of my knowledge. I understand the information is kept confidential and I may be requested to supply additional information. I understand my application for financial assistance cannot be reviewed unless all the information requested is provided. Sanford Health has made no representations that financial assistance is guaranteed.

Name (Print): _____ Signature: _____ Date: _____

Spouse (Print): _____ Signature: _____ Date: _____