Riverwood HEALTHCARE CENTER

Appendix A

Community Care Assistance Program

200 Bunker Hill Drive

Aitkin, MN 56431

The financial information you provide will enable Riverwood Healthcare Center to assist you, the patient/guarantor in determining the level and availability of financial assistance needed to resolve the balance of your Riverwood Healthcare Center accounts.

A copy of your latest Income Tax Return and (2) most recent pay stubs are required.
A recent copy of your bank statements are also required.

Date:	Account Number(s):
Patient/Responsible Party Name:	Date of Birth:
Address:	Apt #
City:	State: Zip:
Years at this address:	
Home Phone:	Work#: Cell#:
Name and age of Dependent(s) other than spouse:	

Employment

Employer	Job Title
Address	Phone #
City	State Zip
Years with this employer:	

Spouse's Name	
Employer	Job Title
Address	Phone #
City	State Zip
Years with this employer:	

Are you a student?..... ☐Yes ☐No

Status:……..……☐Full time ☐Part time

Have you applied for any of the following: Date(s) applied: _____

☐Medicaid ☐Social Security Disability ☐VA ☐Medicare ☐Senior Partners Care

Income & Other Assets

Monthly Net Income	**Assets**
Self (Monthly Net):$	Life Insurance Cash Value: $
Spouse (Monthly Net):$	Stocks/Bonds/Mutual Funds:
Alimony/Child Support: $	Retirement Plans: $

Rent Income: $	Savings Accounts: $
Other: $	Other: $
Total Monthly Income: $	Total Assets: $

Real Estate Description/Location				
Date Acquired	Original Cost	Present Value	Balance Due	Monthly Payment

Vehicles, RV"s etc.				
Year of Vehicle	Date Purchased	Purchase Price	Balance Owing	Monthly Payment

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.

You are further authorized to disclose any information contained herein and other information obtained by you pertaining to my credit and employment history to third parties, for the sole purpose of obtaining financing for payment of any indebtedness that I may owe you.

By signing this agreement, I am promising to cooperate with Riverwood Healthcare Center staff and provide adequate information in a timely manner to resolve my account.

_____ _____ _____

Signature Social Security # Date

_____ _____ _____

Signature Social Security # Date