COOK
HOSPITAL & CARE CENTER
Our Specialty is You

Phone: 218.666.5945
Toll Free: 1.866.324.5945
10 Fifth Street SE
Cook, Minnesota 55723
www.cookhospital.org

PATIENT FINANCIAL SERVICES
Community Benefit (Discount) Program

This is a financial assistance program offered by the Cook Hospital & Care Center. This program is designed to provide full or partial financial relief of hospital bills for medically indicated services to patients without insurance or patients who are underinsured and/or are experiencing financial hardship.

Some services covered by the Community Benefit Program include:

- Laboratory and Radiology services
- Hospital Inpatient stays
- Hospital Observation stays
- Therapy
- Emergency Room visits
- MRIs, Ultrasounds & EMG testing
- Telemedicine

To apply,

1. Complete the attached Community Benefit Program Application
2. Attached income verification paperwork (income tax form, most current pay-check stub, etc.)
3. Return your completed application to Stacy Will by mail, fax (218) 666-6238 or email swill@cookhospital.org.

For questions, contact:

Stacy Will, Director of Revenue Cycle
Cook Hospital & Care Center
218-666-6269

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Cook Hospital & Care Center
COMMUNITY BENEFIT PROGRAM APPLICATION

Date: _____

Patient Applying: _____

Primary Address: _____
Street and/or PO Box City State & Zip Code

Phone Numbers: Home:_____Cell:_____

INCOME VERIFICATION:

Number of Persons in Family:_____
If you claimed more than yourself on your most recent tax return for your exemptions, you must include the additional income that is brought into the household from those individuals that you claimed:
Total Income: Last 12 Months $_____ OR Last 2 Months: $_____

Proof of income must be provided with this application. Please attach copies of one of the following:

- most recent Pay-Check Stub
- current Bank Statement showing proof of income deposits
- most recent Tax Return
- Pension or Social Security Benefit letter

PATIENTS WITHOUT INSURANCE:

Did you apply for your State's Medical Assistance Program(s)?

____YES – If you were denied, attach a copy of the denial letter.

____NO

If the application is approved, the discount amount is valid for one year from the date listed on the approval letter. I understand a false answer to any question in this application is cause for disenrollment of the Community Benefit Program.

Signature:_____***Date:***_____

The Cook Hospital is an equal opportunity provider and employer.