

Kittson Memorial Healthcare Center

1010 S. Birch Ave.
Hallock, MN 56728
218-843-3612

Community Care Application

Name: _____ Birthdate: _____
(Patient)

Social Security Number: _____

Name: _____ Birthdate: _____
(Guarantor/Responsible Party)

Social Security Number: _____

Address: _____
(Guarantor/Responsible Party)

City: _____ State: _____ Zip code: _____

Telephone Number: _____ Marital Status: _____

Number of Dependent Children: _____

Monthly Income:

Current Employer: _____ Spouse's Employer: _____

Self-employed: _____ Self-employed: _____

Have you ever applied for Minnesota Medical Assistance or MN Care? _____

Are you interested in more information or assistance in applying for MN Medical Assistance? _____

Would you like help applying for Minnesota Medical Assistance? _____

Approximate Net annual income (take home pay) for the household: _____

We also need a copy of the following documents:

- Your most recent IRS tax return forms
- Two most recent pay stubs (if applicable)
- Copy of a valid driver's license
- Bank Statement for a self-employed individual

I certify that the above information on this application is true and correct.

Signature of applicant Date

Business Office Approval Date