



**Medical Expenses:** (please attach supporting documentation. Do not include Rainy Lake Medical Center bills, we have those on file):

**Total Medical Expenses:** \_\_\_\_\_

**Prescription Expenses:**(attached supporting documents) \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*The information on this application is true and correct to the best of my knowledge, and I hereby authorize Rainy Lake Medical Center - Hospital Campus to release this information to any physician, clinic, affiliate, and/or other area hospital to which I am referred.*

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Collection Specialist Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administrative Approval

\_\_\_\_\_  
Date

Eligible                       Non-Eligible                      Recommendations \_\_\_\_\_

**IMPORTANT:** *We cannot process applications that aren't complete. Incomplete applications will be returned to you for completion. Thank you.*

**PLEASE BE AWARE THAT THE COMMUNITY CARE PROGRAM DOES NOT COVER PROFESSIONAL FEES INCLUDING BUT NOT LIMITED TO PHYSICIAN BILLING, RADIOLOGIST READINGS, OR AMBULANCE SERVICES NOT BILLED BY RAINY LAKE MEDICAL CENTER.**