First Care
HEALTH CENTER

Financial Assistance Application Instructions

First Care Health Center provides financial assistance and counseling to those who meet set criteria, for uninsured and underinsured people of limited means, without regard to race, ethnicity, gender identity, sexual preference, gender, religion or national origin. Financial assistance includes, but is not limited to, full or partial write off or reduced monthly payments. Information may be obtained by calling our business office at 701.284.7500.

The Financial Assistance Application must be completed, signed and returned with all required documents to help us determine the level of availability of financial assistance.

Extraordinary collection actions, including forwarding balance to a collection agency, reporting to credit bureaus and legal action may occur if the outstanding balance is not resolved.

Required Documentation:

A copy of your most recent tax return.

A copy of your paystubs or bank statements from the past three (3) months.

Family Income:

Amounts listed in this section of the application should include applicants and spouse/significant other's monthly net income. Income includes earnings, unemployment compensation, workers compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments survivor benefits, pension or retirement income, interest dividends, rents, royalties, income from estates, trust, education assistance, alimony, child support, assistance from outside the household and other miscellaneous sources. It does not include non-cash benefits (such as food stamps and housing subsides) or capital gains and losses.

Net Income = Gross Income less taxes.

Signature:

The application process is incomplete unless signed by both you and your spouse/significant other.

Mailing Address:

Please mail application and all supporting documents to:

First Care Health Center
PO Box I
Park River, ND 58270

First Care
HEALTH CENTER

2025 Discount Schedule: (Based on 2025 Federal Poverty Income Guidelines)

Family Size	Less Than/ Equal To	Greater Than	Less Than/ Equal To	Greater Than	Less Than/ Equal To	Greater Than	Less Than/ Equal To
1	$15,650	$15,650	$26,605	$26,605	$31,300	$31,300	$46,950
2	21,150	21,150	35,955	35,955	42,300	42,300	63,450
3	26,650	26,650	45,305	45,305	53,300	53,300	79,950
4	32,150	32,150	54,655	54,655	64,300	64,300	96,450
5	37,650	37,650	64,005	64,005	75,300	75,300	112,950
6	43,150	43,150	73,355	73,355	86,300	86,300	129,450
7	48,650	48,650	82,705	82,705	97,300	97,300	145,950
8	54,150	54,150	92,055	92,055	108,300	108,300	162,450
Each Additional Family Member	Add $5,500						
% of Poverty Level	100%	170%		200%		300%	
Financial Aid Discount	100%	70%		45%		22%	
Patient Share	0%	30%		55%		78%	