

Financial Assistance Application

Patient Section

Name: _____

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Total Family Size: _____

Family Member: _____	Relation: _____
Family Member: _____	Relation: _____
Family Member: _____	Relation: _____
Family Member: _____	Relation: _____
Family Member: _____	Relation: _____
Family Member: _____	Relation: _____

Include with Application:

☐ Pages 1 and 2 of the IRS 1040 Form from the previous year's tax return

Applicant Signature

Date

Business Office Section

Guarantor Account #: _____ Guarantor Name: _____

☐ MN Statute/Uninsured ☐ Eligible – Discount %: _____ Patient Resp. %: _____

☐ Uncompensated Care ☐ Ineligible – Reason: _____

Determined by: _____ Discount Year: _____