Fairview Grand Itasca Clinic and Hospital

750 East 34th Street 1601 Golf Course Road

Hibbing, MN 55746 Grand Rapids, MN 55744

Fax: 218-362-6215 Fax: 218-999-1030

**FINANCIAL ASSISTANCE APPLICATION**

**Patient information** (include all family members applying for charity care)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | Date of birth | Medical record number (if known) |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

**Primary contact information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone numbers: (1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family size:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (include spouse and dependent children)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial information**

Please attach (1) all supporting documents for the boxes you fill out below, and (2) your most recent 1040 Federal Income Tax form. Please only fill out the boxes below that apply to your household. Acceptable supporting documents: payroll stubs from most recent month; statements showing Social Security, unemployment, disability, and spousal/child support benefits; bank and brokerage account statements (for cash or stock); and the most recent year’s tax return. An income statement for self-employed applicants is required. A Declaration of No Income statement will be accepted in the absence of income.

**Monthly income**

|  |  |  |  |
| --- | --- | --- | --- |
| Earned gross income: | $ | Unemployment income: | $ |
| Pension/retirement: | $ | Social Security: | $ |
| County/government assistance: | $ | Child support: | $ |
| Other: | $ | Other: | $ |
| **Assets (what you own)** | | **Retirement savings** | |
| Checking accounts: | $ | Pension/retirement: | $ |
| Savings accounts: | $ | IRA: | $ |
| Health savings accounts: | $ | Other retirement investments: | $ |
| Other: | $ | Certificates of deposit (CD): | $ |

**Medical assistance**

Applied: Yes No Date Applied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Denied: Yes No

The information above is true and correct to the best of my knowledge. If any details are false or incorrect,   
M Health Fairview may stop any discounts I receive.

(*All persons applying over the age of 18 must sign and date below.)*

*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_*