Saint Elizabeth's Medical Center
MINISTRY HEALTH CARE

OFFICE USE ONLY:

Date Received: ____________________
Credit Representative ____________________
Application Processor ____________________
Sup/Mgr/Dir ____________________

Financial Assistance Documentation Checklist

Patient Name: ____________________ Date of Birth: ____________________

Street Address: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Account Number: ____________________ Account Number: ____________________

Account Number: ____________________ Account Number: ____________________

The following information needs to be returned with your completed application.

Attach a **copy** of your most recent Federal and State tax return. If you do not have a copy of your taxes you may call 800.829.1040 and choose the option to receive a transcript. Please follow the phone instructions carefully. This will be sent free of charge. If you have not filed taxes, please complete form 4506-T and return with your Financial Assistance application. We will need confirmation from the IRS as verification of non filing.

Attach a **copy** of your W2's, 1099, schedules and attachments for the same year of the tax return for each employer.

Attach a **copy** of your two most recent pay stubs for each employer for the past 12 months showing year to date gross earnings.

Attach a **copy** of your two most recent monthly personal and business bank statements for each account, including all pages showing all transactions.

Attach a **copy** of your Social Security benefit letter.

Attach a **copy** of your documentation of any unemployment received in the past 12 months. You may call the Department of Workforce Development at the following contacts: For Minnesota -1-877-898-9090 or visit www.uimn.org/applicants/contact-us/ For Wisconsin - 800.494.4944 or visit dwd.wi.gov/ui to request a statement.

Attach a **copy** of your last quarter's entire retirement plan, i.e. 401K, 403B, Roth statements.

Please provide a copy of your most recent Minnesota or Wisconsin Medicaid Determination Letter and/or proof that you applied at the Health Insurance Exchange. **Premiums are required to be paid and up to date or this application may be denied.**

Other: ____________________

Please sign and date the enclosed Financial Assistance Application

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Patient's Name ______________________ Date ______________

Medical Record #or Date of Birth ______________________

Street Address ______________________

Telephone (with area code) ______________________ County ______________

Have you applied at any other Ministry Health Care/Affinity Health System recently? Yes No

If yes, where? ______________________

Responsible Party Name ______________________

Mother Father Self Other

City ______________________ State ______________ Zip Code ______________

Telephone (with area code) ______________________ County ______________

Household Members Name/Relationship/Date of Birth ______________________

____

____

Demographic Information

Responsible Party

Social Security Number ______________________

Employer ______________________

Business Address ______________________

Business Phone ______________________

Occupation ______________________

Length of Employment ______________________

Hourly Wage ___________ Hours Worked ___________

Spouse (If applicable)

Social Security Number ______________________

Employer ______________________

Business Address ______________________

Business Phone ______________________

Occupation ______________________

Length of Employment ______________________

Hourly Wage ___________ Hours Worked ___________

Documentation of ALL income must be provided with your application. Failure to provide documentation may result in a denial of Financial Assistance.

Income Sources – Monthly Gross (Before Taxes)

Responsible Party		Spouse (If applicable)	
Monthly Gross (Before taxes)	$________	Monthly Gross (Before taxes)	$________
Social Security	$________	Social Security	$________
Public Assistance	$________	Public Assistance	$________
Rental Income	$________	Rental Income	$________
Retirement/Pension	$________	Retirement/Pension	$________
Veterans Benefit	$________	Veterans Benefit	$________
Are you a Veteran or entitled to Veterans Benefits?	Yes No	Are you a Veteran or entitled to Veterans Benefits?	Yes No
Unemployment/ Workers Compensation	$________	Unemployment/ Workers Compensation	$________
From________ To ________		From________ To ________	
Alimony	$________	Alimony	$________
Disability	$________	Disability	$________
Other	$________	Other	$________
Total	$________	Total	$________

TOTAL Combined Monthly Gross Income $________

If zero or no income, please explain how you provide for your living expenses:________________

Assets/Savings*

Checking Account(s)	
Bank Location:	*Amount/Value $*
Bank Location:	*Amount/Value $*
Savings Account(s)	
Bank Location:	*Amount/Value $*
Bank Location:	*Amount/Value $*
Certificate of Deposit(CD)	
Bank Location:	*Amount/Value $*
Stocks/Bonds	
Bank Location:	*Amount/Value $*
Other(IRAs/Mutual Funds/401K/403B,etc.)	
Bank Location:	Amount/Value $

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Monthly Expenses

Child Support	*Medications*	*Health Insurance*	
$	$	$	

TOTAL Combined Expenses $______________ (monthly, charge accounts, medical and other)

Have you applied for any state/county assistance program/healthcare.gov? Yes No

If yes, Program__________________________________ County____________________________

Date Applied____________________ Application: Accepted Denied Pending **Proof Required

I attest that the above information is true to the best of my knowledge and I authorize Ministry Health Care/Affinity Health System to verify any information for their confidential use in determining my ability to pay for medical services. Providing false information will void this application.

______________________________ ________________ ________________
Responsible Party's Signature Relationship Date

Note: If all required documentation is not enclosed, application may not be considered. Additional information may be requested upon review of the application.