Unity MEDICAL CENTER
For Your Health

PLEASE RETURN BY_____

Financial Assistance Application Form

Failure to provide required information – your application will be immediately denied.

Name of Guarantor: _____

Date of Birth: _____ Social Security Number: _____

Address: _____
Number and Street City State Zip

Daytime Phone Number_____ Cell Phone Number_____

Email Address_____

Place of Employment _____ Job Title_____

PART TIME/FULL TIME (Please Circle) Average hours worked per week_____

Wage per hour_____

Employer's Name_____ Employer's Phone Number_____

Spouse or Significant Other Name _____

Date of Birth: _____ Social Security Number: _____

Address: _____
Number and Street City State Zip

Daytime Phone Number_____ Cell Phone Number_____

Email Address_____

Place of Employment _____ Job Title_____

PART TIME/FULL TIME (Please Circle) Average hours worked per week_____

Wage per hour_____

Employer's Name_____ Employer's Phone Number_____

Is there any family members not covered by insurance? If so why? _____

Household Information: List ALL dependents of your household who were claimed on your most recent IRS Form 1040. (If more dependents please list on back of page.)

Names	Relationship to Patient	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Required Documents:

- **A copy of your most recent Household Federal Income Tax Return (IRS FORM 1040A)**
- **Most recent W-2 from all working household members**
- **2 check stubs from all working household members**
- **2 recent bank statements from all financial institutions for checking and savings accounts**
- **If Self-employed, 2 most recent Business Account Bank Statements; most recently filed business tax return including all Schedule: Business Income Statements and Accounts Receivable Ledger.**
- **Copies of any income from the following:**
    - **Social Security and or Disability**
    - **Workers compensation**
    - **Supplemental Security income**
    - **Public assistance**
    - **Veteran's survivor benefits payments**
    - **Pension or retirement income**
    - **Alimony, child support & interest dividends**
- **A Medicaid Denial Letter or proof of an application, if applicable**
- **Forms approving or denying Unemployment compensations or Workers' Compensation**
- **Pending Social Security Disability claim information, if applicable**

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges at UMC (medical care, including hospital and physician services) and will be kept confidential. I understand that the materials I send to prove my income will not be returned. I further understand that the information I submit concerning my annual family income and family size is subject to verification by UMC. I understand that if any information I gave to determined financial assistance is considered to be false, will cause my application to be denied. I understand by not paying any remaining balance after application approval will cause the approval to be null and void. I will immediately become liable for the full balance before the Financial Assistance approval.

My signature authorizes UMC to verify all information provide on this form. I certify that the above information is true and accurate to the best of my knowledge. This applications will be considered incomplete unless signed by you and your spouse or significant other.

Guarantor Signature_____

Spouse or Significant Other Signature _____

Please mail application and all supporting documents to:

Unity Medical Center

% Financial Counselor

164 West 13th St.

Grafton, ND 58237