PLEASE RETURN BY: _____

Financial Assistance Application Form

Please fill out form and return with the required documentation.
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) Wage per hour: _____

Average hours worked per week: _____

Employer's Name: _____ Employer's Phone Number: _____

Spouse/ 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) Wage per hour: _____

Average hours worked per week: _____

Employer's Name: _____ Employer's Phone Number: _____

Are 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.)

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

One or more of the Required Documents:

- **A copy of the most recent Household Federal Income Tax Return (IRS FORM 1040A)**
- **Two (2) most recent check stubs from all working household members**
- **If Self-employed, two (2) most recent Business Account Bank Statements**
- **Copies of any income from the following:**
  - **Social Security and/or Disability**
  - **Supplemental Security income**
  - **Public assistance (Heating, rent, childcare &/or food assistance)**
  - **Alimony or child support**
- **A Medicaid Denial Letter or proof of application, 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 information sent to verify my income will not be returned.
- I understand that UMC Financial Assistance will only be available for the current and prior calendar year.
- I understand that any remaining balance will be set up on an automatic payment plan, which will be automatically taken out of my credit/debit card, checking, or savings account.

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

Guarantor Name: _____ Account Number: _____

Guarantor Signature: _____

Spouse/Significant Other Signature: _____

Please mail application and all supporting documents to:

Unity Medical Center
c/o Financial Counselor
164 West 13th St.
Grafton, ND 58237