Unity MEDICAL CENTER
For Your Health

PLEASE RETURN BY 08/22/2020

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/ 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 you most recent IRS Form 1040. (If more dependents please list on back of page.)

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

Required Documents:

- **A copy of the 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.**
- **If Self-employed, two most recent Business Account Bank Statements and most recently filed business tax return including all Schedules: 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 payments survivor benefits**
  - **Pension or retirement income**
  - **Alimony, child support, & interest dividends**
- **A Medicaid Denial Letter or proof of 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 information submitted regarding my annual family income and family size is subject to verification by UMC.
- I understand that if any of the information given to determined financial assistance is considered to be false, my application will be denied.
- 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 saving account.

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 application will be considered incomplete unless signed by you and your spouse/significant other.

Guarantor Name & Account Number_____

Guarantor Signature _____

Spouse/Significate Other Signature _____

Please mail application and all supporting documents to:

Unity Medical Center
% Financial Counselor
164 West 13th St.
Grafton, ND 58237

Revision date: 07/22/2020

DUE 08/22/20

Guarantor Name & Account Number:_____

Applicant is: Eligible_____ Percent discounted _____

Denied _____

Reason for denial_____

_____

Signed _____

Date Applicant was provided with a copy of determination: _____

Revision date: 07/22/2020