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/ 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 your most recent Household Federal Income Tax Return (IRS FORM 1040A)**
- **Most recent W-2**
- **2 check stubs from any working household member**
- **2 recent bank statements from all Financial Institution for checking and savings**
- **If Self emplyed, your 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 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' Compensatio**
- **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 concidered 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 your and your spouse/significant other.

Guarantor Signature_____

Spouse/Significate Other Signature _____

Please mail application and all supporting documents to:

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

Guarantor account number_____

Applicant is: Eligible_____ Partial payment_____ Percent discounted_____

Denied _____ Reason for Denial _____

_____

Signed _____

Date Applicant was provided with a copy of determination: _____