FINANCIAL ASSISTANCE APPLICATION

Date: ____________________ Your Account #: ________________________ (this is your guarantor # from your statement)

Guarantor Name: ____

Guarantor Address: ____

City: __________________________ State: _____________ Zip: ___________ Phone #:__________________________

Did you know that Essentia Health has a program that may help you with your medical bills, called the **Financial Assistance Program**? Please complete the application below. If not complete, your application may be denied. If approved, your application is valid for 12 months from the date we receive it. If you need help filling out this application, or have other questions, please call our office. We can help you!

In order to qualify for this program, you must:

- Apply for Medical Assistance and other forms of public/private assistance depending on applicable eligibility guidelines.
- Have a determination of any Medical Assistance disability claim.
- Cooperate with your Workers Compensation, auto or any other insurance carrier requirements.
- Have received medically necessary, eligible services delivered through Essentia Health that are covered under our program. *For a list of exclusions, please contact us or visit www.essentiahealth.org, select Patients & Visitors, select Billing and Financial Assistance.*
- Reportable assets may not exceed $75,000 for a household of one, or $150,000 for a household of two or more.

If you have medical bills for the following facilities, please check all boxes that apply:

☐ Essentia Health ☐ Midwest Medical ☐ Essentia Health Ambulance

Please list below only those people who live in your household and are claimed on taxes. This would include your spouse and children under the age of 18.

First and Last Name	Date of Birth	Relationship to you	Does this person have Medical Assistance? Yes/No - Explain
1.)		Self	
2.)			
3.)			
4.)			
***If you have additional people, please add them on a separate piece of paper and include with your application**			

It is **required** that you apply for Medical Assistance if your family is within your State Medicaid Program income guidelines. Please contact your State Medicaid Program with questions on their eligibility guidelines.

Medical Assistance Application ~ Have you included your Award/Denial Letter from Medicaid?	
This applies to me (copy included)	Doesn't apply to me

*If you have insurance at the time of approval and your coverage changes or cancels, you will need to provide proof of new coverage or a Medicaid determination letter prior to any further adjustments being made.

Account #: ________________________ (This is your guarantor # from your EH statement)

Required Documentation of Income Verification (if applicable) Please include for ALL household members (listed above)	**Please circle if this does/doesn't apply to you** Don't forget to include copies	
Federal Tax Return Last year's Federal Tax Return 1040 including schedule C, E and/or F if applicable	**This applies to me** (copies included)	Doesn't apply to me
Employment Income (wages) Last 2 full months (60 days) of employment pay stubs	**This applies to me** (copies included)	Doesn't apply to me
SSI, SSDI, RSDI Income Copy of 2 most recent bank statements showing deposits	**This applies to me** (copies included)	Doesn't apply to me
Unemployment / Work Comp Benefits / Disability Copy of pay history printout	**This applies to me** (copies included)	Doesn't apply to me
Spousal, Child Support Copy of 2 most recent bank statements showing deposits	**This applies to me** (copies included)	Doesn't apply to me
Pension, Annuity, VA Benefits Copy of 2 most recent bank statements showing deposits	**This applies to me** (copies included)	Doesn't apply to me
Other Sources of Income (Tribal, Per Capita, TANF, MFIP, etc.) Copy of 2 most recent bank statements showing deposits	**This applies to me** (copies included)	Doesn't apply to me

No Income? Please explain how you support yourself on a separate page. For example: daily living expenses such as food, gas, housing and other bills.

Required Documentation of Assets / Other Property (if applicable) Please include for ALL household members (listed above)	**Please circle if this does/doesn't apply to you** Don't forget to include copies	
****Checking, Savings, Flex, HSA, HRA, etc.** Last 2 months of bank statements for **each** type of account	**This applies to me** (copies included)	Doesn't apply to me
Other Property Owned (besides your primary home) Last year's property tax statement for **each** property	**This applies to me** (copies included)	Doesn't apply to me
Retirement & Investment Accounts: **IRAs, 401Ks, Stocks, Bonds, Life Insurance, etc.** Most recent statement(s) for **each** account	**This applies to me** (copies included)	Doesn't apply to me

** **With all Checking, Savings, Flex, HSA, HRA, etc., please include ALL UNALTERED PAGES (including blank pages) with an EXPLANATION OF ALL DEPOSITS**

Reminders on filling out the application:

- Be sure you complete the entire application and answer all the questions.
- Attach copies of all documents needed (do not send originals).
- **Sign and date** the application and return it to Essentia Health as soon as possible.
- Any payment plans will remain in effect on your account while you apply for this program; please continue to make your payments timely.
- Collection attempts will continue to take place on your account until the application is returned with complete information.

****Your application may be denied if all required information is not submitted. ****

Mail completed applications for East, Central and West markets to:
Essentia Health
Attn: BSC - Financial Assistance
400 E Third Street
Duluth, MN 55805
***** Or you can scan and e-mail your information to financialassistanceappinfo@essentiahealth.org*****

I/we hereby request that Essentia Health make a determination of my eligibility for the Essentia Health Financial Assistance Program. I acknowledge that the information provided in this application is true and correct. I understand that the information that I submit will be subject to verification by Essentia Health as an audited program, and if this is determined to be false, it will result in a denial of the Essentia Health Financial Assistance Program. Failure to fully complete this application and provide supporting documents may result in denial of the application.

Applicant's Signature ____ **Date** ____________________