FINANCIAL ASSISTANCE APPLICATION

507.831.2400 | 888.425.9936
contactus@windomareahealth.org
2150 Hospital Drive | P.O. Box 339
Windom, MN 56101

Submit application to address listed to right or deliver to Front Desk at Windom Area Health.

Guarantor Name:	Spouse Name:	
Street Address:	Spouse Occupation:	
City, State, Zip:	List Dependents Living in Household & Age:	
Phone:		
Guarantor Occupation:		

Income & Assets

Monthly Gross Income	**Self**	**Spouse**
Gross Income/Unemployment/Work Comp	$	$
Social Security/SSI/SSDI	$	$
Self-employment/Rental Income/Royalties/Estates/Trusts	$	$
Retirement/Pension/Annuities/Veteran's Benefits	$	$
Child Support/Spousal Support/Public Assistance	$	$
Miscellaneous/Other Income (List nature of Other Income):	$	$
Total Monthly Income	$	$

Do you own or rent your home? OWN RENT Monthly payment $ Market Value $	Net Worth of Business Owned $
Vehicle(s) owned (make & year):	Other Assets:

	Account With:	***Balance:***
Checking Account		
Savings Account		
Investments		

Any other information you would like us to consider:

____

____

____

____

____

____

____

____

____

____

Liabilities	List banks, credit cards, and store charge cards, where you have accounts.			
		Account With:	***Balance Owing:***	***Monthly Payment:***
	Auto Loan			
	Auto Loan			
	Other Loans			
	Other Loans			
	Credit Cards			
	Credit Cards			
	Credit Cards			
	Credit Cards			
	Other Obligations (include alimony, child support payments, etc)			
	Total Payments $		$	$
		Account With:	***Balance Owing:***	***Monthly Payment:***
	Medical Expenses			

Are you a member of a Health Cost Sharing Organization (such as Christianhealthcare, Medi-Share, Liberty)? YES NO

Have you ever declared bankruptcy? YES NO If so, when?

Have you ever received welfare benefits from any governmental or other third party source (county welfare payments, food stamps, Medicaid, Emergency Energy Assistance, etc.)? YES NO

I attest that I have included the following required documents with my completed application:

- ☐ Tax Return (Federal 1040)
- ☐ 2 paystubs for each wage earner
- ☐ Social Security Award letter (if applicable)
- ☐ 2 months of Bank Statements
- ☐ If uninsured, provide a copy of your Medicaid denial letter

Assignment of Rights (Please Read Carefully)

By signing below, I certify that the information on this application and the supporting documentation are true and correct to the best of my knowledge. I understand the information is kept confidential and I may be requested to supply additional information.
I understand my application for financial assistance cannot be reviewed unless all the information requested is provided.
Windom Area Health has made no representations that financial assistance is guaranteed.

Name (Print): ______________________ Signature: ______________________ Date: __________

Spouse (Print): ______________________ Signature: ______________________ Date: __________