ESSENTIA HEALTH FINANCIAL ASSISTANCE APPLICATION

Please complete the application below. If not complete, your application will be denied. If approved, your application is valid for 12 months from the date we receive it.

Name:____

Address: ____

City __________________________ State _____________________ Zip ___________

Your Essentia Health Account Number _________________________________

Medical Record #__________________

Please list the people who live in your household and who are claimed on taxes. 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.)			
5.)			
6.)			

COMPLETE DOCUMENTATION NEEDED FOR ITEMS BELOW

Required Information for ALL household members (if applicable):	Send Copies of:	Documents Included: Circle if Apply
Federal Tax Return	**Did You File Taxes Last Year?**	**Y / N**
	Last year's Federal Tax Return 1040 including schedule C, E and/or F if applicable	**Y / N**
Employment Income (wages)	Last 2 full months (60 days) of employment pay stubs	**Y / N**
SSI, SSDI, RSDI Income	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**Y / N**
Unemployment / Work Comp Benefits / Disability	Benefit Letter AND a copy of pay history printout	**Y / N**
Spousal, Child Support	Benefit Letter AND a copy of 2 most recent bank statements showing deposits	**Y / N**
Pension, Annuity, VA Benefits	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**Y / N**
Other Sources of Income (Tribal, Per Capita, TANF, MFIP, etc.)	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**Y / N**
Medical Assistance Application	Award / Denial Letter from the County	**Y / N**
No Income: Please explain how you support yourself. For example: daily living expenses such as food, gas, housing and other bills.	**Please provide a separate page with your explanation.**	
Assets / Other Property:	**Send Copies of:**	**Documents Included: Circle if Apply**
Reportable assets may not exceed $25,000 for a household of one or $50,000 for a household of two or more		
Checking, Savings, Flex, HSA's, HRA, etc.	Last 2 months of bank statements for each type of account **ALL PAGES & AN EXPLANATION OF DEPOSITS**	**Y / N**
Other Property Owned (besides your primary home).	Last year's property tax statement for **each** property	**Y / N**
Retirement & Investment Accounts: IRAs, 401Ks, Stocks, Bonds, Life Insurance, etc.	Most recent statement(s) for **each** account	**Y / N**

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 _________________

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