UNITED HOSPITAL DISTRICT
Blue Earth, Minnesota

OFFICE USE ONLY:
Date due to Hospital: _____
Date Rec'd by Hospital: _____
Approved: ____ Denied: ____
UHD Representative

FINANCIAL ASSISTANCE APPLICATION

Please help us to assist you in determining your eligibility for Financial Assistance.
To be completed by the Applicant (please print)

FAMILY INFORMATION:

Applicant Name: _____
First Middle Last

Spouse's Name: _____ Telephone Number _____

Current Address: _____
Number & Street City State Zip

Applicant's Employer _____ Occupation _____

Spouse's Employer _____ Occupation _____

Dependents: Include only those dependents that you can claim on your income tax return:

Name	Relationship	Age

Are any members of your family unable to work due to age, illness or injury? _____

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INCOME:

List income from all sources for both applicant and spouse. If self-employed or farmer, list net income.

SOURCES	**Last 3 months**			**Last 12 months**	
	Applicant	**Spouse**		**Applicant**	**Spouse**
Regular Wages					
Farm or self-employment					
Social Security					
Unemployment					
Workmen's Compensation					
Public Assistance					
Alimony					
Child Support					
Pensions					
Income from dividends, interest or rent					
Income from prize winnings lottery					
Military family allotments					
Other income					
TOTAL INCOME					

Explanation of any recent major change in income (attach page if necessary)

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EXPENSES:

List expenses for all dependents, including applicant and spouse

Description	Monthly	Total Amount Owed
Food/Groceries		
Electricity		
Natural Gas/Fuel Oil		
Water/Sewer		
Water Softener		
Phone		
Land Line		
Cell		
Internet		
TV		
Garbage Service		
Insurance		
Health		
Auto		
Home		
Life		
Other		
Daycare		
Child Support Payments		
Church/Charities/Gifts		
Clothing		
Rent/Mortgage		
Auto		
Loan 1		
Loan 2		
Gasoline		
Repair/Maintenance		
Medical		
United Hospital		
Doctor/Clinic		
Doctor/Clinic		
Other Hospital		
Dentist		
Eye Doctor		
Chiropractor		
Other Medical		
Credit Cards (list)		
TOTAL EXPENSES		

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ASSETS:

Checking Account Balance _____ as of (date)_____

Savings Account Balance _____ as of (date) _____

Other Balance _____ as of (date) _____

Investments Balance _____ as of (date) _____

Home: Rent_____ Own_____ If owned, value _____

Other owned property: _____

Vehicles:

Model: _____ Year_____ Value: _____

Model: _____ Year_____ Value: _____

Model: _____ Year_____ Value: _____

Business or farm equipment: List separately, including type of equipment, model (if appropriate), value and loan balance (if any).

Other assets not listed above, describe and indicate value:

TOTAL ASSETS: _____

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LIABILITIES:

Property Loans:

Home:

Primary Mortgage Balance_____ as of (date)_____ # of payments remaining _____

Equity Loan Balance_____ as of (date)_____ # of payments remaining _____

Other Property Loan Balance_____ as of (date)_____ # of payments remaining _____

Auto Loans Balances:

Loan 1: _____ as of (date)_____ # of payments remaining _____

Loan 2: _____ as of (date)_____ # of payments remaining _____

Loan 3: _____ as of (date)_____ # of payments remaining _____

Other loans outstanding not listed above, describe and indicate balances and payments remaining:

TOTAL LIABILITES: _____

Are there any other medical or financial problems within the family unit? If so, please describe.

Has the patient filed for bankruptcy in the past 3 years?

Comments regarding your application not addressed anywhere else.

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Supporting documents required:

Bank statements for Social Security or direct deposit
Pay stubs/W-2 forms
Latest filed Federal Income Tax Return (1040 and attachment)
Receipts (as necessary to support expenses identified)

I understand that the information, which I submit for verification by United Hospital District, will be subject to further review. I certify that the information provided in this is true and correct to the best of my knowledge.

_____ _____

Applicant's signature Date