CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

Financial Assistance Application

For questions regarding this application, call 218-546-7000 and ask for a Financial Advisor.
This form collects information that is not part of the medical records. For local storage only.
Complete the following application: (In black or blue ink)

Applicant Name (First, Middle, Last)	Service Location	Today's Date

Patient / Responsible Party

Name (First, Middle, Last)		Social Security Number	Date of Birth	
Address	City		State	ZIP Code
Primary Phone		Household Size (Patient, Spouse & Dependents)	Marital Status	
Employment Status ☐ Full Time ☐Part Time ☐ Self Employed ☐Unemployed ☐ Student			Employer Name	

Please list the people who live in your household (list only members that you would claim on your taxes)

First & Last Name	Date of Birth	Relationship to you	Has this person applied for Medical Assistance? Yes / No - Explain
1.		Self	
2.			
3.			
4.			
5.			
6.			

Bank Account(s), Provide 2 months of statements

Bank Name	Account Type	Balance	Bank Name	Account Type	Balance
	Checking			Checking	
	Savings			Savings	

*Are you eligible for insurance from an employer? ☐ Yes ☐ No
Do you currently have coverage through MNSure, Private Plan, MNCare or Medical Assistance? ☐ Yes ☐ No

Insurance

Type	Policy With	Carrier of Insurance
Health		
Health		
HSA / Flex Plan	Balance:	

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320 EAST MAIN, CROSBY, MN 56441

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CHECK ALL APPLICABLE ITEMS AND ATTACH SUPPORTING DOCUMENTATION

Required Information for ALL household members (if applicable		Send Copies of:	Monthly / Yearly Amount (Gross)	
	Federal Tax Returns	Last year's Federal Tax Return 1040 including schedule C, E and/or F, if applicable	**$**	**Yearly**
	Employment Income (Wages)	Last 3 full months of employment pay stubs	**$**	**Monthly**
	SSI ,SSDI, RSDI Income	Award Letter or bank statement showing deposit	**$**	**Monthly**
	Unemployment / Work Com Benefits / Disability	Benefit Letter or copy of pay history printout	**$**	**Monthly**
	Spousal, Child Support	Benefit Letter or a copy of the 2 most recent bank statements showing deposits	**$**	**Monthly**
	Pension, Annuity, VA Benefits	Award Letter(s) or a copy of the 2 most recent bank statements showing deposits	**$**	**Monthly**
	Other Sources of Income, (Tribal, Per Capita, TANF, MFIP, etc)	Award Letter(s) or a copy of the 2 most recent bank statements showing deposits	**$**	**Monthly**
	Medical Assistance Application	Award / Denial Letter from the County		
	Check here if you Did Not File Taxes Last Year	**Total Income: $_____**		
	No Income: Please explain how you support yourself. For example: Daily living expenses such as food, gas, housing and other bills			

Employment

Family Member	Relationship to applicant	Employer	How Often Paid: Weekly, Bi-Weekly, Twice per Month, Monthly	Salary or Hourly Wage (amount)	Hours worked per week

Certification:

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services proved by Cuyuna Regional Medical Center. I give permission to Cuyuna Regional Medical Center to share the information as necessary to consider my financial assistance request. I hereby grant permission to Cuyuna Regional Medical Center to investigate the information contained herein this application.

Patient / Responsible Party Signature	Date
Spouse / Partner Signature	Date

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