



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 F	Party								
Name (First, Middle, Last)	Social Security Number			Date of Birth					
Address	City	Sta			State	tate ZIP Code			
Primary Phone		Household Size (Patient, Spouse & Dependents)			e &	Marital Status			
Employment Status ☐ Full Time ☐ Part Time	mployed ☐Unemployed ☐ Student			Employer Name					
Please list the people who live in your household (list only members that you would claim on your taxes)									
		Date of Birth	th you ' Assi		Assis	this person applied for Medical stance? / No - Explain			
1.			Self				prom.		
2.									
3.									
4.									
5.									
6.									
Bank Account(s), Prov	ide last :	2 montl	ns of statem	ents					
Bank Name	Accoun Type	t	Balance		Bank Name		Accour		Balance
	Checkin						Checkir	•	
	Savings						Savings	5	
*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									
nsurance Type Policy With		With			Carrier	of Insur	ance		
Health		l	**!(!!			Jarrier	JI IIIJUI	aiio c	
Health									
HSA / Flex Plan		Baland	ce:						

Cuyuna Regional Medical Center / Sleep Center of Central MN Updated: 1/11/2022



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Sleep Center of Central Minnesota

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 (CRMC) or Sleep Center of Central MN. I give permission to CRMC or Sleep Center of Central MN to share the information as necessary to consider my financial assistance request. I hereby grant permission to CRMC or Sleep Center of Central MN to investigate the information contained herein this application.

Patient / Responsible Party Signature	Date
Spouse / Partner Signature	Date

Return application and supporting documents to: CRMC 320 E. Main St. Crosby, MN 56441 Attn: Financial Services

Cuyuna Regional Medical Center / Sleep Center of Central MN

Updated: 1/11/2022