crmc. Financial Assistance Application

Please complete all sections of the form and include the required documents listed on the checklist. **Applications cannot be processed without proper documentation.** If you have questions or need help filling out this form, our financial advisors are here to help.

Call 218-546-7000

Mail or deliver this application to:

Cuyuna Regional Medical Center
Attn: Business Office
320 E Main Street, Crosby, MN 56441

Preferred CRMC Location: ☐ Crosby ☐ Crosby Super One ☐ Baxter ☐ Breezy Point ☐ Longville

Patient Information

Patient Name (First Middle Last)	Birth Date (mm/dd/yyyy)	Phone Number	
Address	City	State	ZIP Code
Employment Status ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Student		Employer Name	

Household Information

Household Size (Include patient, spouse, and dependents as listed on income taxes)	Household Annual Income (As reported on income taxes)

☐ Check here if you are claimed as a dependent on someone else's tax return. **Attach a copy of that tax return**.

Marital Status

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow	Spouse's Name (First Middle Last)	Birth Date (mm/dd/yyyy)
Spouse's Employment Status ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Student		Employer Name

Dependents

Name	Relationship	Birth Date	Employment Status	Monthly Income
1.				
2.				
3.				
4.				
5.				

Medical Insurance

Health Plan Provider	Who Is the Policy Holder?	Who Is Covered?
1.		
2.		

Are you eligible for health insurance through an employer? ☐ Yes ☐ No

Supporting Documents

☐ **You filed taxes last year**
- Include your **federal tax return (Form 1040)**
- If you are self-employed, include **Schedule C, E, and/or F**

☐ **You did NOT file taxes last year**
- Include your most recent **W-2** or **Form 1099** from any employer(s), if available.

Check all that apply and include supporting documents. Including proof of income is critical to your application.

☐ **Pay Stubs**
Two most recent pay stubs for any working household members, including the patient, spouse, or dependents

☐ **Social Security**
Benefit verification letter from the Social Security Administration

☐ **Unemployment, Workers' Compensation, or Disability**
Benefit award letter or payment statement

☐ **Child Support**
Court order, payment record, or letter from a child support enforcement agency

☐ **Spousal Support (Alimony)**
Divorce decree, legal agreement, or a court-issued payment record

☐ **Pension or Annuities**
Payment summary or annual award letter from the plan provider

☐ **Veterans Benefits**
VA Benefit Summary Letter from the U.S. Department of Veterans Affairs

☐ **Other Income (Death Benefits, Estate Distributions, Tribal Payments, MFIP, General Assistance, etc.)**
Award letter or payment statement from the agency or program

☐ **Bank Accounts**
Most recent 2 months of statements for all checking and savings accounts

☐ **Benefit Accounts**
Two most recent statements from accounts such as health savings accounts (HSAs) or flexible savings accounts (FSAs)

☐ **Medical Assistance (Medicaid)**
Approval or denial letter for coverage for each individual member

If you have no income, explain how you pay for daily living expenses such as food, gas, housing, and other bills:

Certification

I certify that the information provided in this application is true and correct to the best of my knowledge. I understand that CRMC will use this information to determine my ability to pay for services. I give permission for CRMC to share and verify this information as needed to process my financial assistance request.

Printed Name of Patient or Responsible Party	Relationship to Patient (if not the patient)
Signature	Date