Date Received :_____

Office Use Only
Medical Record #:_____ Qualifies for_____% Discount

in House Hold:_____ Total Income:_____

PLEASE RETURN BY: _____

MINIDOKA MEMORIAL HOSPITAL

Financial Assistance Application

Include with this application:

- ☐ Copy of your last year's income tax
- ☐ Copy if Medicaid or County
- ☐ Copy of current Utility Bill
- ☐ Your three most recent bank statements
- ☐ Last 3 months of check stubs
- ☐ Copy of your Company's most recent income statement

Tell Us Who You Are

YOURSELF/APPLICANT Mark here if this is the Patient?____

First Name, Middle Initial, Last Name:_____

Date of Birth:_____ Social Security #_____ Sex: ☐M ☐F Marital Status_____

Day Time Phone Number:_____ Message Phone:_____

Physical Address:_____ City_____ State___Zip Code_____

Mailing Address:_____ City_____ State__Zip Code_____

County:_____ From:_____ To:_____

E-mail Address:_____ Are you a Veteran?_____

CO-APPLICANT / SPOUSE / SIGNIFICANT OTHER Mark here if this is the Patient?____

First Name, Middle Initial, Last Name:_____

Date of Birth:_____ Social Security #_____ Sex: ☐M ☐F Marital Status_____

Day Time Phone Number:_____ Message Phone:_____

Physical Address:_____ City_____ State___Zip Code_____

Mailing Address:_____ City_____ State__Zip Code_____

County:_____ From:_____ To:_____

E-mail Address:_____ Are you a Veteran?_____

Tell Us About the People Who Live With You

OTHER (Child, Roommate, Parent, etc.) Mark here if this the Patient?___

First Name, Middle Initial, Last Name:____

Date of Birth:______________ Social Security #__________________Sex: ☐M ☐F Relationship___________

Did the dependent live with you for more than 6 months?_______________________

Are they Claimed as a dependent on someone's else's tax return who does not live with you?__________

OTHER (Child, Roommate, Parent, etc.) Mark here if this the Patient?___

First Name, Middle Initial, Last Name:____

Date of Birth:______________ Social Security #__________________Sex: ☐M ☐F Relationship___________

Did the dependent live with you for more than 6 months?_______________________

Are they Claimed as a dependent on someone's else's tax return who does not live with you?__________

OTHER (Child, Roommate, Parent, etc.) Mark here if this the Patient?___

First Name, Middle Initial, Last Name:____

Date of Birth:______________ Social Security #__________________Sex: ☐M ☐F Relationship___________

Did the dependent live with you for more than 6 months?_______________________

Are they Claimed as a dependent on someone's else's tax return who does not live with you?__________

OTHER (Child, Roommate, Parent, etc.) Mark here if this the Patient?___

First Name, Middle Initial, Last Name:____

Date of Birth:______________ Social Security #__________________Sex: ☐M ☐F Relationship___________

Did the dependent live with you for more than 6 months?_______________________

Are they Claimed as a dependent on someone's else's tax return who does not live with you?__________

OTHER (Child, Roommate, Parent, etc.) Mark here if this the Patient?___

First Name, Middle Initial, Last Name:____

Date of Birth:______________ Social Security #__________________Sex: ☐M ☐F Relationship___________

Did the dependent live with you for more than 6 months?_______________________

Are they Claimed as a dependent on someone's else's tax return who does not live with you?__________

Tell Us About Your Income and Resources

Earned Income

Patient/Applicant

Current Employer Name:_____ Phone Number_____

Address (Street, City, State, Zip):_____

Hours per Week:_____ Hourly Rate:_____ Monthly Gross_____

List Dates of Employment: From:_____ To:_____

Please Provide Current Copies of Check Stubs

Spouse/Significant Other/Co-Applicant

Current Employer Name:_____ Phone Number_____

Address (Street, City, State, Zip):_____

Hours per Week:_____ Hourly Rate:_____ Monthly Gross_____

List Dates of Employment: From:_____ To:_____

Please Provide Current Copies of Check Stubs

Other Household Member

Current Employer Name:_____ Phone Number_____

Address (Street, City, State, Zip):_____

Hours per Week:_____ Hourly Rate:_____ Monthly Gross_____

List Dates of Employment: From:_____ To:_____

Please Provide Current Copies of Check Stubs

Other Household Member

Current Employer Name:_____ Phone Number_____

Address (Street, City, State, Zip):_____

Hours per Week:_____ Hourly Rate:_____ Monthly Gross_____

List Dates of Employment: From:_____ To:_____

Please Provide Current Copies of Check Stubs

Unearned Income

Is anyone receiving income from the following sources? Check all that apply.

Social Security	Veteran's Benefits	Food Stamps	Cash Assistance
Worker's Compensation	Child Support	Alimony	Employer Disability
Crime Victims	Unemployment	Energy Assistance	School Financial Aide
Retirement	Tribal/BIA Assistance	Commodities	Rental/Escrow
Inheritance/Trust	Loans/Gifts	Insurance Settlements	Church
Income Tax Refunds/Earned Income Credit		Inters/Dividends	Other

Please Provide Details for any Unearned Income Marked Above

Source of Unearned Income	Person Receiving Income	Amount	How Often?

Your Expenses

List all expenses for anyone in your household. Include anything you have or your name appears on, even as a co-signer.

Items	Monthly Amount	Balance Owed	Name(s) on Account	Paid to:
Rent or Mortgage (If zero, why?)				
2nd Mortgage				
Space Rent				
Electricity				
Water/Sewer/Trash				
Heat (Gas)				
Telephone				
Cell Phone				
Cable TV				
Food				
Non-Food				
Health/Accident Ins.				
Home Owners/Rentals Ins.				
Life Insurance				
Auto Insurance				
Car Payment				
2nd Car Payment				
Fuel				
Credit Card				
Hospital				
Doctors				
Medication				
Dental				
Other				
Property Taxes				
Payroll Taxes				
Education Expenses				
Child Care				
Child Support				
Garnishment				
Fines				
Other				
Other				
TOTAL				

Assets

List all assets for anyone in your household. Include anything your have or your name appears on, even as a co-signer.

Item	Have It?		Item Description	Owner(s)/Name On Account	Bank Name/Item or Account Location	Value/ Amount	Amount Owed
	yes	no					
Cash							
Checking Acct.							
Savings Acct.							
Line of Credit							
CDs/Mutual Funds							
Stocks/Bonds							
Trust/Annuities							
Retirement (IRA, 401K, Etc.)							
Credit Card							
Other Financial							
Home/Residence							
Land							
Rental Property							
Vehicle(s)							
Vehicle(s)							
Recreational Vehicles (Campers, Trailer, ATVs.)							

Sign Your Signature (must be complete)

I affirm that the information I have provided is true and complete. Individuals that falsify the Financial Assistance Application will not be eligible for the program. My/our signature(s) on this form give Minidoka Memorial Hospital authorization to verify the information on the form including permission to contact employers.

Signature of patient or guarantor _____ Date _____

Signature of Co-applicant _____ Date _____