GLACIAL RIDGE
HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

Name		Spouse Name		
Mailing Address		City	State	Zip Code
Primary Phone #	Alternate Phone #	# of Dependents		

INCOME

List income for family from:	**Last 1 Month**	**Total for Last 12 Months**
Wages or Farm / Self-Employment Income Before Deductions		
Pension / Retirement		
County/Government Assistance		
Social Security / Disability		
Worker's or Unemployment Compensation		
Child Support		
Spousal Support		
Income from Dividends and Interest		
Income from Rent		

ASSETS

Please provide the dollar value in:	**Last 1 Month**	**Total for Last 12 Months**
Savings Accounts		
Stocks, Bonds, CD's		
Property Owned – not residence		
Cash Value of Life Insurance Policies		
Other Investments		
Other Liquid Assets		

Glacial Ridge Health System requires thorough documentation from those applying for financial assistance discounts. Please make sure you have all documentation to support your claims in the sections above.

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EXPENSES

Please provide the dollar value in:	Last 1 Month	Total for Last 12 Months
House payment/Rent		
Property Taxes (if applicable)		
Utilities:		
Electric/Gas/Oil		
Phone/Internet/Cable		
Water/Sewer/Garbage		
Insurance:		
Health		
Auto/Home		
Loan payments (personal, auto, boat, etc.)		
Credit Cards		
Other Expenses (list)		

FINANCIAL DOCUMENTATION REQUIRED

Please provide the following documentation if applicable:

- IRS 1040 Tax Return, W-2s, and supporting schedules for the most recent year
- Pay Stubs for the last 2 months
    - If you did not file a tax return last year, please provide pay stubs for the last 3 months.
- Statement of Pension / Retirement Income
- Statement of Social Security / Disability Benefits
- Statement of Worker's Compensation / Unemployment Compensation
- County / Government Assistance
- Child Support / Spousal Support
- Bank Statements for the last 2 months for all accounts
- Invoices or Statements for the last 2 months for all expenses listed

Please fill out the attestation on the next page in order for us to process your application. We will do our best to process your application quickly and painlessly, but we often need to follow up with the applicants for more thorough documentation or information. We thank you in advance for your patience and cooperation.

If you feel that your concerns have not been addressed, please contact us at 320-634-4521 first and allow us the opportunity to try to address your concerns. If you continue to have concerns that have not been addressed, you may contact the Minnesota Attorney General's Office by telephone at 651-296-3353 or 1-800-657-3787, by email at hospital.billing@AG.state.mn.us, or online at www.AG.state.mn.us/contact.

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☐ I have included the required financial documentation listed on the previous page.

☐ I affirm the information in this application is true and correct to the best of my knowledge.

☐ I understand that misrepresenting any information on this application could result in denying my financial assistance application request.

Individuals who do not have the supporting documents, have questions, or need assistance with the application may contact our Patient Account Representative at 320-634-4521.

Date _____ Applicant Signature _____

Relation to Applicant, if not the Applicant Signature _____

Comments _____

_____

_____

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_____

Submit completed application and supporting documents required in person or by mail to:

Glacial Ridge Health System
Attn: Patient Account Rep
10 Fourth Avenue SE
Glenwood, MN 56334

FOR OFFICE USE ONLY

CEO/Administrator	Date	Chief Financial Officer	Date
Denied / Approved and Percentage Discount Reasons			