Rainy Lake MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Patient/Responsible Party

Name ______________________________ DOB ______________

Address ______________ City ______________ State ________ Zip Code__________

Phone Number ______________________________ SSN______________

Spouse ______________ Spouse SSN______________ Spouse DOB ______________

List Persons in Household (do not include those listed above)

Dependent Name	Date of Birth Month/Day/Year

Employment Information

☐ Employed ☐ Self Employed ☐ Seasonal ☐ Unemployed ☐ Retired

- If Employed, Self-Employed, or Seasonally Employed please provide most recent pay stubs and tax information
- If Retired, please a copy of Bank Statement showing Social Security deposit
- If Unemployed, please provide Unemployment Compensation information – including denial letter
- Supply Medical Assistance denial letter if applicable

Monthly Income

Patient: $____________
Spouse: $____________
Interest/Dividends: $____________
Other: $____________
Total: $____________

Do any other persons contribute financially to the family? ☐ Yes ☐ No
If Yes, amount $____________

Patient Information

HOME: ☐ Own ☐ Rent Name of Mortgage or Landlord ______________________

Monthly Payments $____________ ______________________
Address

Bank Information

Please attach a copy of your Bank Statement

Bank Name ______________________________
Address ______________________________ State________ Zip Code____________

Account Type	Account #	Account Balance
☐ Checking ☐ Savings		

Medical Expenses: (please attach supporting documentation. Do not include Rainy Lake Medical Center bills, we have those on file):

Total Medical Expenses: ______________________________

Prescription Expenses:(attached supporting documents**)**

____

Remarks:______________________________

____

____

____

____

____

____

The information on this application is true and correct to the best of my knowledge, and I hereby authorize Rainy Lake Medical Center - Hospital Campus to release this information to any physician, clinic, affiliate, and/or other area hospital to which I am referred.

______________________________ ______________________________

Applicant's Signature Date

______________________________ ______________________________

Collection Specialist Signature Date

______________________________ ______________________________

Administrative Approval Date

☐ Eligible ☐ Non-Eligible Recommendations ______________________________

IMPORTANT: ***We cannot process applications that aren't complete. Incomplete applications will be returned to you for completion. Thank you.***

PLEASE BE AWARE THAT THE FINANCIAL ASSISTANCE PROGRAM DOES NOT COVER PROFESSIONAL FEES INCLUDING BUT NOT LIMITED TO PHYSICIAN BILLING, RADIOLOGIST READINGS, OR AMBULANCE SERVICES NOT BILLED BY RAINY LAKE MEDICAL CENTER.