



Financial Assistance Application

This form collects information that is not part of the medical record. **For local storage only.**

Applicant Name <i>(First, Middle, Last)</i>	Services Locations	Mayo Clinic Number
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Instructions: Complete application and attach copies of:

- Tax returns and supporting schedules (previous 2 years)
- Social Security benefits* (if applicable)
- On a separate page describe your need for financial assistance*
- Pay stubs* (most recent 3 months)
- Bank statements* (most recent 3 months for all accounts)
- W-2 or Unemployment Statements*

*Not applicable for Barron, Cameron, Rice Lake, Mondovi, Osseo, Elmwood or Menomonie, WI

I have applied for or will apply for federal or state medical assistance or have verified my healthcare exchange plan eligibility. <input type="checkbox"/> Yes <input type="checkbox"/> No Reason _____
I have a lawsuit, settlement, personal injury, or liability claim pending. <input type="checkbox"/> Yes <input type="checkbox"/> No Reason _____
I have the availability of insurance through my employer or my spouse's employer. <input type="checkbox"/> Yes <input type="checkbox"/> No Reason _____
I have previously applied for financial assistance at another Mayo Clinic facility. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Where _____ When _____

Patient/Responsible Party

Name <i>(First, Middle, Last)</i>	Social Security Number	Birth Date <i>(Month DD, YYYY)</i>
Address	City	State ZIP Code
Phone	Household Size (Patient, Spouse and Dependents)	Marital Status
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	Employer Name	
Employment Length	Unemployed Date/Length <i>(Month DD, YYYY)</i>	Are you claimed on another tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes provide tax returns of those being claimed)

Spouse/Partner

Name <i>(First, Middle, Last)</i>	Social Security Number	Birth Date <i>(Month DD, YYYY)</i>
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student	Employer Name	
Employment Length	Unemployed Date/Length <i>(Month DD, YYYY)</i>	

Dependents (If more than 4 dependents use separate page)

Full Name	Relationship	Birth Date <i>(Month DD, YYYY)</i>
1.		
2.		
3.		
4.		

Applicant Name <i>(First, Middle, Last)</i>	Mayo Clinic Number
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Bank Account(s) Not applicable for Barron, Cameron, Rice Lake, Mondovi, Osseo, Elmwood or Menomonie, WI

Bank Name	Account Type	Bank Name	Account Type
	Checking		Checking
	Savings		Savings
	Other Investments and Securities		Other Investments and Securities

Property Not applicable for Barron, Cameron, Rice Lake, Mondovi, Osseo, Elmwood or Menomonie, WI

Type	Detail	Estimated Value	Unpaid Balance
Secondary Residence/Vacation Home			
Land	Number of Acres		
Rental Property			
Business/Farm Equipment			
Other/Recreational Vehicle			

Provide documentation for any of the following sources of income

Income Description	Source	Monthly Income Amount
Interest/Dividends		
Pension/Retirement		
Rental/Property		
Disability		
Alimony/Child Support		
Other		

Insurance

Type	Policy With	Monthly Payment
Health		

Medical Debt

Type	To Whom	Unpaid Balance	Monthly Payment
Medical Doctor			
Medical Hospital			
Other			

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 provided by Mayo Clinic or an affiliated entity and I give permission to Mayo Clinic and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Mayo Clinic, all Mayo Clinic affiliates and representatives or agents to investigate the information contained herein, and to obtain credit reports.

Patient/Responsible Party Signature	Date <i>(Month DD, YYYY)</i>
Spouse/Partner Signature	Date <i>(Month DD, YYYY)</i>