

**JOHNSON MEMORIAL HEALTH SERVICES  
1282 WALNUT STREET  
DAWSON, MN 56232  
REQUEST FOR FINANCIAL ASSISTANCE**

If you have any questions, please call our Patient Account Representative at 320-769-4393, ext. 2388 or toll free at 888-769-2164.

Date of Application: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_

**FAMILY INFORMATION:** Please list name and age of all persons living in household. If persons are over 18 please indicate if student and/or working.

(Section 1)

NAME	RELATIONSHIP	AGE

(Section 2)

**INCOME INFORMATION (Only if applying for both uninsured and Charity Care discounts):**

- Please provide a copy of your most current Tax Return.

	Self	Spouse	Others
<b>Gross Monthly Income:</b>	\$ _____	\$ _____	\$ _____

**Any other income not included above, such as: child support, Social Security, pensions, etc.**  
Please list below.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Page 2)

\*\*\*\*\*If you are NOT applying for the Charity Care program, do not fill out sections 3 - 5\*\*\*\*\*

(Section 3)

In order to qualify for the Charity Care program, you must apply for Medical Assistance in your county first.

Have you applied for Medical Assistance with your county? Yes\_\_ No\_\_(please check one)

If No, you must do so.

If Yes, what was the outcome? (If denied, attach copy of denial)\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Section 4)

**MONTHLY EXPENSES:**

House: Own Rent (Circle one) \$\_\_\_\_\_ Electric: \$ \_\_\_\_\_  
Heat/Gas \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_  
Food \$ \_\_\_\_\_ Car Loan \$ \_\_\_\_\_  
Insurance Premiums \$ \_\_\_\_\_ Charge Acct Balance \$ \_\_\_\_\_  
Child Care: Alimony payments Day Care (Circle One) \$ \_\_\_\_\_

Other Medical Expenses: \_\_\_\_\_

\_\_\_\_\_

Other Financial Obligations \_\_\_\_\_

\_\_\_\_\_

(Section 5)

**CREDIT ACCOUNTS:**

CHECKING BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

SAVINGS BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

CD'S BANK: \_\_\_\_\_

BALANCE: \_\_\_\_\_

**ASSETS:** Land Property Vehicles Other

Value: \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

(Section 6)

**APPLICANT'S COMMENTS: Please tell why you need to file this form, or other information that will help us make a determination on this account**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do not write below this line

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Adjustment % Approved \_\_\_\_\_ Adjustment Amt. Approved \_\_\_\_\_

DOS Covered \_\_\_\_\_ to \_\_\_\_\_ Applicants Share still owing \$ \_\_\_\_\_

Applicant to pay \$ \_\_\_\_\_ Month \$ \_\_\_\_\_ Lump Sum \$ \_\_\_\_\_

Comments:

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Approved By: \_\_\_\_\_ Denied By \_\_\_\_\_

Date: \_\_\_\_\_