

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

It is the policy of Johnson Memorial Health Services, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon the family/household size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic and ER, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services.

If you have any questions, please call our Patient Account Representative at 320-312-2136 or toll free at 888-769-2164.

This form must be completed every 6 months or if your financial situation changes.

Name of Head of Household		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Number of related persons living in your household:

Please list spouse and dependents under age 18.

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income (Please include a copy of your most current tax return)

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment and dependents				
Rent, interest, dividend, and other income				
Total Income				

Expenses

Description	Weekly Amount	Monthly Amount	Annual Amount
House: Own Rent (Circle One)	\$	\$	\$
Heat/Gas	\$	\$	\$
Food	\$	\$	\$
Insurance Premiums	\$	\$	\$
Electric	\$	\$	\$
Phone	\$	\$	\$
Car Loan	\$	\$	\$
Charge Account Balance	\$	\$	\$
Child Care: Alimony Payments Day Care (Circle One)	\$	\$	\$
Other Medical Expenses	\$	\$	\$
Other Financial Obligations	\$	\$	\$

If there are Other Medical Expenses and Other Financial Obligations, please provide a brief explanation below.

Net Income

Total Annual Household Income	\$
Less: Annual Expenses	\$
Net Income	\$

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) _____

Verification Checklist (attach copies)	YES	NO
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other	<input type="checkbox"/>	<input type="checkbox"/>
Income: Prior year tax return, three most recent pay stubs, or other	<input type="checkbox"/>	<input type="checkbox"/>
Insurance: Insurance card(s)	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid: Application made or evidence of rejection	<input type="checkbox"/>	<input type="checkbox"/>

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

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print):	Date:
Signature:	

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Adjustment % Approved _____ Adjustment Amt. Approved _____

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

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

Comments:

Approved By: _____ Date: _____

Denied By: _____ Date: _____