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MAYO CLINIC

Financial Assistance Application

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For local storage only.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

Applicant Name *(First, Middle, Last)*	Service Location

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*

I have applied for or will apply for federal or state medical assistance or have verified my health care exchange plan eligibility.*

☐ Yes ☐ No Reason _____

I have a lawsuit, settlement, personal injury, or liability claim pending.

☐ Yes ☐ No Reason _____

I have the availability of insurance through my employer or my spouse's employer.

☐ Yes ☐ No Reason _____

Household Annual Income (as reported on income tax filing)	Household Size (patient, spouse, and dependents as reported on income tax filing)

Patient or Responsible Party

Name *(First, Middle, Last)*			Birth Date *(mm-dd-yyyy)*
Address	City	State	ZIP Code
Phone	Marital Status*		
Employment Status ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Student		Employer Name	
Employment Length	Unemployed Date/Length *(mm-dd-yyyy)*	Are you claimed on another tax return? ☐ Yes ☐ No (If "Yes," provide tax returns.)	

Spouse or Partner (Used to identify all patient accounts eligible for financial assistance)

Name *(First, Middle, Last)*		Birth Date *(mm-dd-yyyy)*
Employment Status ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Student		Employer Name
Employment Length	Unemployed Date/Length *(mm-dd-yyyy)*	

*Not applicable for NHSC locations including Barron, Cameron, Rice Lake, Mondovi, Osseo, Menomonie, WI, or Albert Lea MN Behavioral Health (including Fountain Centers).

Dependents (If more than 4 dependents use separate page)

Full Name	**Relationship**	**Birth Date** *(mm-dd-yyyy)*
1.		
2.		
3.		
4.		

Financial Assistance Application (continued)

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

Other Income

Description	Monthly Income Amount

Medical Debt

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

Certification Signatures

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.

Patient or Responsible Party Signature ▶ Signature Required	Date Today *(mm-dd-yyyy)*
Responsible Party Printed Name *(First, Middle, Last)*	
Spouse or Partner Signature ▶ Signature Required	Date Today *(mm-dd-yyyy)*
Spouse or Partner Printed Name *(First, Middle, Last)*	

Print