Complete and print.

Reset Form

MAYO CLINIC

Financial Assistance Application

Form content not retained in medical record.
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	

Service Location

Instructions: Complete application and attach copies of:

- Tax return from current or prior year (or W-2 if tax not available)
- Unemployment statements (if applicable)
- Pay stubs (most recent month)
- Social security, pension, retirement benefits (if applicable)
- Bank statements (most recent month for all accounts)

If the above copies are not available, provide a separate page describing your current financial situation.

Patients seen only at Oakridge in Mondovi, Wisconsin or Albert Lea, Minnesota Behavioral Health are only required to complete the application and attach copies of **one** of the following:

- Prior year W-2 (or Form 4506-T if W-2 not filed)
- Two most recent pay stubs
- Income verification from employer

Patient or Responsible Party Completing This Application

Patient Name (First Middle Last)			Birth Date (mm-dd-yyyy)	
Address	City		State	ZIP Code
Responsible Party Completing the Application (if not the Patient) (First Middle Last)		Relationship to the Patient (if not the Patient)		
Household Annual Income (as reported on income tax filing)	Household Size (patient, spouse, and dependents as reported on income tax filing)			
Phone	Medical Insurance Name and Policy Number			
Employment Status ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Student ☐ Retired		Employer Name		
Employment Length	Unemployed Date/Length (mm-dd-yyyy)	Are you claimed on another tax return? ☐ Yes ☐ No (If "Yes," provide tax return.)		

Dependents (If more than 6 dependents, use separate page)

Full Name (First Middle Last)	Relationship	Birth Date (mm-dd-yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

Financial Assistance Application (continued)

(complete fields or place patient label here)

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

Patients seen only at Oakridge in Mondovi, Wisconsin or Albert Lea, Minnesota Behavioral Health do not need to complete the following spouse section:

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

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

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 ▶	Date (mm-dd-yyyy)
Responsible Party Printed Name (First Middle Last)	

Print