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Reset Form

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)*	Services Locations

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, Menomonie, WI or Albert Lea, MN Behavioral Health (including Fountain Centers)

I have applied for or will apply for federal or state medical assistance or have verified my healthcare 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 _____

I have previously applied for financial assistance at another Mayo Clinic facility.
☐ Yes ☐ No ☐ Not sure
Where _____ When _____

Patient/Responsible Party

Name *(First, Middle, Last)*		Social Security Number	Birth Date *(mm-dd-yyyy)*	
Address		City	State	ZIP Code
Phone	Household Size (Patient, Spouse and Dependents)		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 of those being claimed)	

Spouse/Partner

Name *(First, Middle, Last)*	Social Security Number	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)*	

Dependents (If more than 4 dependents use separate page)

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

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Financial Assistance Application

(continued)

(complete fields or place patient label here)

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

Bank Account(s)

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

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, Menomonie, WI or Albert Lea, MN Behavioral Health (including Fountain Centers)

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 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, and to obtain credit reports.

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

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