

ORTONVILLE AREA HEALTH SERVICES
 Financial Assistance Program Application
 Financial Information
 320-839-4096

Applicant _____
 Co-Applicant _____
 Address _____

Family Size:
 Applicant _____
 Co-Applicant _____
 Dependent Children _____
 Total _____

Telephone # H _____
 W _____

Housing Rent: _____/Month

ASSETS

Home:
 Taxable Assessed Value \$ _____
 Balance of Mortgage \$ _____
 Monthly Payment \$ _____

Other Real Estate-Desc. _____
 Taxable Assessed Value \$ _____
 Balance of Mortgage \$ _____
 Monthly Payment \$ _____

Automobile #1
 Make/Model/Year _____
 Monthly Payment _____

Automobile #2
 Make/Model/Year _____
 Monthly Payment _____

INCOME

(Weekly/Biweekly/Monthly)

Gross Wages-Applicant \$ _____
 Gross Wages-Co-applicant \$ _____
 Disability Income \$ _____
 Alimony \$ _____
 Child Support \$ _____
 Rent Income \$ _____
 Unemployment \$ _____
 Investment Income \$ _____
 Gross Soc Security-Appl \$ _____
 Gross Soc Security-CoAppl \$ _____
 Earnd Inc Cr(L38a Fed Tx) \$ _____
 Other _____ \$ _____
 Total \$ _____

Checking Balance \$ _____
 Savings Balance \$ _____
 Investments \$ _____

COPIES OF THE FOLLOWING ARE REQUIRED IN ORDER TO PROCESS YOUR APPLICATION

(If These Are Not Applicable To You Please Indicate "NA")

Checking Account Statements (last 2 months) _____
Savings or Investments Statements (last 2) _____
Payroll (Last 2 pay vouchers) _____
Federal Income Tax Return (last calendar year) _____
Notification of Social Security Benefits _____

Our signatures below indicate that the above information is accurate.

SIGNATURES:

Applicant _____
 Co-applicant _____

Date _____
 Date _____

Please return this application along with
 any required copies to:

Kevin Benson, CFO
 Ortonville Area Health Services
 450 Eastvold Avenue
 Ortonville, MN 56278

(5/16/14)