ORTONVILLE AREA HEALTH SERVICES

Financial Assistance Program Application

Financial Information

320-839-4096

Applicant_____

Co-Applicant_____

Address_____

_____

Telephone # H_____

W_____

Family Size:

Applicant	
Co-Applicant	
Dependent Children	
Total	

Housing Rent:_____/Month

ASSETS

Home:

Taxable Assessed Val	$
Balance of Mortgage	$
Monthly Payment	$

Other Real Estate-Desc._____

Taxable Assessed Val	$
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 _____ Date _____

Co-applicant_____ Date _____

Please return this application along with any required copies to:

Patient Financial Services
Ortonville Area Health Services
450 Eastvold Avenue
Ortonville, MN 56278

(02/19/19)