Winona Health Services Financial Assistance Application

Complete the application and provide copies of the following information:

	Federal tax return (1040 form) or proof of gross yearly income if no taxes are filed
	Last tax return for patient and tax return for whomever claims the patient as a dependent
	Recent bank statement
	Last Payroll check stub
	Recent balances of any FSA, HSA, HRA
	If no insurance, letter of explanation as to why Applicant/Patient, Spouse and/or dependents do not have insurance coverage

Applicant/Patient

Name:		Date of Birth (MM/DD/YYYY):		
Address:		City:	State:	Zip:
Primary Phone:	Secondary Phone:	Marital Status: ☐Married ☐Widowed ☐Divorced ☐Never Married ☐Legally Separated		
Have you been offered healthcare insurance through your employer? ☐Yes ☐No If yes, list insurance:				

Spouse

Name:	Date of Birth (MM/DD/YYYY):	Primary Phone:
Have you been offered healthcare insurance through your employer? ☐Yes ☐No If yes, list insurance:		

Dependents

Name:	Date of Birth (MM/DD/YYYY):	Relationship:

Assets

Bank Accounts:	Bank Name:	Balance:
Checking/Saving:		$
Investments (CDs):		$
FSA, HSA, HRA balances:		$

I verify that the information provided in this application is accurate and subject to verification. Should any of the information proved to be false, I understand that it may result in the denial of any benefit for which I may have been eligible. If denied, I further understand that I will be liable for any outstanding charges and/or balances.

Applicant Signature:	Date:

Please return completed application and information to: **Winona Health Services, Attn: Business Office, P.O. Box 5600, Winona, MN 55987**
If you have questions regarding this process, contact: **Winona Health Business Office, 507.457.4488**