# Winona Health Services Financial Assistance Application

**Complete the application and provide copies of the following:**

- Federal tax return (1040 form) or proof of gross yearly income if no taxes are filed
- Need tax return for patient and whomever claims the patient as a dependent
- Recent bank statement

## 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: | | $ |
| Savings: | | $ |
| Investments (CDs): | | $ |
| Other: | | $ |

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