

Winona Health Services Financial Assistance Application

Complete the application and provide copies of the following:

- Federal tax return (1040 form) and supporting schedules or copy of social security card if no tax return filed
- Recent bank statement
- *If you have had income changes in the last year, please provide last three months of income (pay stubs or bank statements)*

Applicant/Patient

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

Spouse

Name:	Date of Birth (MM/DD/YYYY):	Primary Phone:
Have you been offered healthcare insurance through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
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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**

