Duluth Family Medicine Clinic

Financial Assistance Program Application

Date: _____

Guarantor Name: _____
Guarantor Address: _____
City _____ State _____ Zip _____

Re: Your DFMC Account Number _____

Did you know that DFMC has a program that may help you with your medical bills, called **Patient Assistance Program**? You may be eligible to have your bills reduced if your income falls between the guidelines listed below:

Household Size	**100% Discount** If Income is less than:	**75% Discount** If Income is less than:	**50% Discount** If Income is less than:
1	$19,008	$26,730	$36,828
2	$25,632	$36,045	$49,662
3	$32,256	$45,360	$62,496
4	$38,880	$54,675	$75,330
5	$45,504	$63,990	$88,164
6	$52,128	$73,305	$100,998

For families/households with more than 6 persons, add $4,160 for each additional household member

In order to qualify for the Financial Assistance Program you must:

- Apply for Medical Assistance and other forms of public/private assistance depending on applicable eligibility guidelines.
- Have a determination of any Medical Assistance disability claim.
- Cooperate with your workers compensation, auto or any other insurance carrier requirements.
- Have received medically necessary, eligible services delivered through DFMC that are covered under our program. Please contact us for a list of exclusions.
- Reportable assets may not exceed $25,000 for a household of one, or $50,000 for a household of two or more.

Reminders on filling out the application:

- Be sure you complete the entire application and answer all of the questions.
- Attach copies of all documents needed (do not send originals).
- Sign and date the application and return it to the DFMC Business Office within 30 days from the date this application was mailed.
  Your application may be denied if all required information is not submitted.*

Mail or drop off this application and the requested copies to:

Duluth Family Medicine Clinic
330 N 8th Ave 3
Duluth, MN
55805
218-529-9126

Please contact us if you have any questions about your eligibility for this program.

Guarantor _____ Medical Record #_____

Please complete the application below. Please note that additional documentation may be requested to complete the review of your application. If approved, your application is valid for 6 months from the date we receive it. If you need help filling out this application, or have other questions, please call our office. We will be happy to help.

Please list the people who live in your household (list only household members that you would claim on your taxes).

First and Last Name	Date of Birth	Relationship to you	Does this person have Medical Assistance? Yes/No - Explain
1.)		Self	
2.)			
3.)			
4.)			
5.)			
6.)			

CHECK BOXES FOR ALL APPLICABLE ITEMS IN YOUR HOUSEHOLD

	Required Information for ALL household members (if applicable):	Send Copies of:	Yearly Amount (Gross)
	Federal Tax Return	Last year's Federal Tax Return 1040 including schedule C, E and/or F if applicable	**$**
	Employment Income (wages)	Last 2 full months (60 days) of employment pay stubs	**$**
	SSI, SSDI, RSDI Income	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**$**
	Unemployment / Work Comp Benefits / Disability	Benefit Letter AND a copy of pay history printout	**$**
	Spousal, Child Support	Benefit Letter AND a copy of 2 most recent bank statements showing deposits	**$**
	Pension, Annuity, VA Benefits	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**$**
	Other Sources of Income (Tribal, Per Capita, TANF, MFIP, etc.)	Award Letter(s) AND a copy of 2 most recent bank statements showing deposits	**$**
	Checking, Savings, Flex, HSA's, HRA, etc. *Flex/HSA/HRA accounts must have a balance less than $25.00*	Last 2 months of bank statements for each type of account	**$**
	Medical Assistance Application	Award / Denial Letter from the County	**$**
	Check Here if You Did Not File Taxes Last Year	**Total Income: $_____**	
	No Income: Please explain how you support yourself. For example: daily living expenses such as food, gas, housing and other bills.		
	Other Property / Assets:	**Send Copies of:**	**Estimated Value**
	Other Property Owned (besides your primary home).	Last year's property tax statement for **each** property	**$**
	Retirement & Investment Accounts: IRAs, 401Ks, Stocks, Bonds, Life Insurance, Pension Plan, etc.	Most recent statement(s) for **each** account	**$**

I/we hereby request that DFMC make a determination of my eligibility for the Financial Assistance Program. I acknowledge that the information provided in this application is true and correct. I understand that the information that I submit will be subject to verification by DFMC, and if this is determined to be false, it will result in a denial of the application for financial assistance. Failure to fully complete this application and provide supporting documents may result in denial of the application.

Applicant's Signature _____ Date _____