MEEKER MEMORIAL
HOSPITAL & CLINICS

612 S. Sibley Ave.
Litchfield, MN 55355
(320) 693-4500
meekermemorial.org

Financial Assistance Application

Instructions:

Please complete the application form and provide copies of the required documents. This information will help us assess your financial situation and determine your ability to pay for medically necessary services provided by Meeker Memorial Hospital and Clinics. Note that until your financial statement has been reviewed and approved by our Patient Financial Services staff, you will be financially responsible for your medical care.

If you are uninsured, you MUST apply for Medical Assistance through MNSURE before you can qualify for financial assistance. Please attach a copy of the Medical Assistance denial letter or a screen print of your denial from the MNSURE website.

Please include a copy of the following items if applicable:

- ❑ Most recent 1040 Federal Tax Return
- ❑ Last 4 most recent paystubs for you and your spouse
- ❑ Last 3 bank statements for you and your spouse
- ❑ Unemployment history page showing your weekly unemployment benefits
- ❑ Social Security Award letter of Form SSA 1099 – Social Security benefit statement
- ❑ Pension benefit letter

Please note that failure to send all information could result in a denial or assistance. It is important to make sure all of your documents are included with your application.

Please return the completed application and documents to us via email financialassistance@meekermemorial.org, fax 320-693-4545, or mail to:

Meeker Memorial Hospital & Clinics
612 S. Sibley Ave
Litchfield, MN 55355

If we have any questions for you, we will call you at the number listed on the application or send you a letter.

If you have any questions regarding financial assistance, please contact our Financial Assistant Advocate at 1-320-693-4596. The Financial Assistant Advocate will return your call within 48 hours.

Thank you,

Meeker Memorial Hospital & Clinics

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NAME: First _____ MI _____ Last _____

ADDRESS: (Number and Street Name) (City) (State) (Zip)

_____

PHONE: Home: _____Cell: _____ DATE OF BIRTH: _____

EMPLOYER: _____

OCCUPATION: _____ DATE OF HIRE: _____ EMPLOYER PHONE: _____

SPOUSE NAME: First _____ MI _____ Last _____

ADDRESS: (Number and Street Name) (City) (State) (Zip)

_____

PHONE: Home: _____Cell: _____ DATE OF BIRTH: _____

EMPLOYER: _____

OCCUPATION: _____ DATE OF HIRE: _____ EMPLOYER PHONE: _____

DID YOU FILE TAXES LAST YEAR? Y _____ N_____

DO YOU HAVE A BANK CHECKING OR SAVINGS ACCOUNT? Y_____ N_____

DO YOU HAVE MEDICAL INSURANCE? Y____ N____

INSURANCE NAME: _____ID#-_____Spouse ID# _____

DEPENDENTS

Name	Relationship	Date of Birth	Insurance ID#

I affirm the above information is true and correct to the best of my knowledge. I also authorize Meeker Memorial Hospital & Clinics to verify any information listed above.

_____ _____
Guarantor Signature Date

_____ _____
Spouse Signature (required if married) Date

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*Please Provide Monthly Income for Account Holder and for Spouse

Monthly Income:			
Wages	$ / month	Unemployment	$ / month
Pension / Retirement	$ / month	Social Security	$ / month
Alimony / Child Support	$ / month	Income from Rental Property	$ / month
Other Income	$ / month		

**If Liquid Assets are greater than $500,000 you are not eligible for Financial Assistance

Liquid Assets: (assets transferable to cash)			
Checking Account	$	Health Savings Account	$
Savings Account	$	Pension / Retirement	$
IRA / CD's	$	Recreational Vehicles (campers, boats, motorcycles, etc..)	$
Property (does not include your home)	$	Other Assets	$

***Need to complete information below only if assets are over $300,000

Expenses:			
Rent / Mortgage	$ / month	Phone	$ / month
Utilities	$ / month	Day Care	$ / month
Child Support	$ / month		$ / month
Other Expenses	$ / month		