



Financial Application
Gillette Children's Specialty Healthcare
Attention: Patient Accounting
200 East University Avenue
St. Paul, MN. 55101

Responsible party/Guarantor_____

Patient's Name_____

Account Number_____ Date of Application_____

Address_____

City_____ State_____ Zip_____

Date of Birth_____ Social Security Number_____

Spouse's Name_____

Date of Birth_____ Social Security Number_____

Names and ages of dependents living with you.

_____ age_____ age_____

_____ age_____ age_____

_____ age_____ age_____

Please answer each question below in as much detail as possible. Attach a copy of your most recent federal income tax return, a copy of most recent pay stub. If you are currently unemployed the documentation to show dollars you will be receiving.

Your place of employment_____

Address of employment_____

Hourly wages_____ Number of hours per week_____

Deductions from paycheck other than taxes_____

Spouse's place of employment_____

Address of employment_____

Hourly wages_____ Number of hours per week_____

Deductions from paycheck other than taxes_____

Other Sources of income List dollars per month

Social Security_____ Rental property:_____

Pension/Retirement_____ Interest/Dividends_____

Alimony, maintenance or support_____ Other_____

AFDC/State or Federal Support_____

Do you own or rent your home_____ How long have you lived at this address_____

Do you own other real estate_____ Value of real estate, other than your home_____

Do you own a motor vehicle____If yes, list make, model, year and monthly payment (if any)

List recreational vehicles (RV's, boats, snowmobiles, ATV's etc.) and monthly payment (If any)

Monthly Expenses

Rent or Mortgage payment_____

Real estate taxes (if not included in monthly payment)_____

Heat _____

Electricity _____

Water/Sewer _____

Telephone _____

Prescription/medical Supplies _____

Auto insurance _____

Health Insurance (if not deducted from payroll) _____

Homeowner/Renters Insurance _____

Life insurance premium _____

School tuition/programs (Specify below) _____

Other (Specify below) _____

Monthly Installment payments
Creditor

Balance owed

Monthly payment

Do you plan to file, or have you filed a lawsuit or insurance claim against someone because of an accident or injury?_____

If yes, name, address and phone number of attorney_____

Do you have any pending lawsuits against you_____

List any judgments against you_____

Have you applied for Medical Assistance_____ County application submitted to _____
_____If you have and were denied, when_____

I understand that the information, which I have provided is subject to verification by Gillette Children's Specialty Healthcare and may be reviewed by federal and state agencies for other program-related purposes. I also understand that that my application is subject to guidelines of Gillette Children's Specialty Healthcare and that eligibility will be determine at its sole discretion. I certify that all the above information is true and correct.

I/We hereby authorize Gillette Children's Specialty Healthcare to obtain federal and state records of employment and income history, including State Employment Security Agency records. This authorization applies only to this transaction and continues in effect for one (1) year unless limited by state law, in which case the authorization continues in effect for the maximum period allowed by law, not to exceed one (1) year. A photographic copy of the authorization (i.e., the signature(s) of the undersigned) may be accepted as the original and may be used as a duplicate original.

Signature_____Date_____

Spouse's
Signature_____Date_____

To be considered this application must be submitted complete with all requested information. Incomplete forms will not be considered. Your acceptance or denial will be be mailed to you. This is a **ONE TIME ONLY** program. Should your application not be accepted you may apply again, if your financial status changes.