Gillette Children's
Specialty Healthcare

STAFF USE ONLY	
Sent on:	
Return by:	
Patient Name:	
Medical Record #(MRUN):	

Application for Gillette Assistance Program

Please complete the following application and return with ALL requested information. Applications with incomplete forms and/or missing verification(s) will not be considered. You may mail your application to:

Gillette Children's Specialty Healthcare
Attn: Charge Integrity—GAP
Internal Zip #010609
200 University Ave. E.
St. Paul, MN 55101

Or you may fax it to: 651-325-2174.
If you have questions, please call 651-325-2177. You may also email financialassistance@gillettechildrens.com.

BEFORE YOU SUBMIT YOUR APPLICATION
ü Sign and date application
ü A copy of your most recent federal income tax return, with all schedules, must be included with the application.
Black out ALL Social Security numbers and bank account numbers

APPLICANT INFORMATION					
Responsible Party/Guarantor		Date of Birth			
Street Address					
City		State		ZIP	
Phone		Email			
Marital Status:		Spouse's Name:		Date of Birth	

DEPENDENT INFORMATION			
Name	Date of Birth	Relationship to Guarantor	Gillette Patient?
Total Number in Household:			

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EMPLOYMENT AND INCOME INFORMATION						
Applicant	☐ Employed	☐ Homemaker	☐ Unemployed			
	☐ Retired	☐ Disabled	☐ Student			
Name of Employer		Gross Monthly Income		Seasonal?		
How Often Are You Paid?	☐ Weekly	☐ Biweekly	☐ Twice a Month	☐ Monthly	☐ Other	
Spouse	☐ Employed	☐ Homemaker	☐ Unemployed			
	☐ Retired	☐ Disabled	☐ Student			
Name of Employer		Gross Monthly Income		Seasonal?		
How Often Are You Paid?	☐ Weekly	☐ Biweekly	☐ Twice a Month	☐ Monthly	☐ Other	

OTHER SOURCES OF INCOME		
Type of Income	Amount	How Often?
Social Security/Disability Benefits		
Pension/Retirement Income		
Alimony, Maintenance or Support		
Government Assistance		
Interest/Dividends		
Other		

INSURANCE INFORMATION			
Do You Have Current Medical Insurance Coverage?		Name of Insurance Company	
Policyholder Name		Policy Number	
Name of Secondary Insurance Company (If Applicable)			
Policyholder Name		Policy Number	
Have You Applied for Medical Assistance?		If Yes, When Did You Apply?	

***IF YOU WERE DENIED MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF YOUR DENIAL LETTER**

I understand that the information 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 the guidelines of Gillette Children's Specialty Healthcare and that eligibility will be determined at its sole discretion. I certify that all the above information is true and correct.

I/We hereby supply Gillette Children's Specialty Healthcare with federal and state records of employment and income history, including State Employment 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_____

Submit this application with ALL requested information. Incomplete forms will not be considered. Tax information must have your tax preparer's information OR be signed by the taxpayer(s). You will receive a letter notifying you of Gillette Children's Specialty Healthcare's decision to approve or deny your request for assistance. Should your application be denied, you may apply again if your financial status changes.