STAFF USE ONLY	
Sent On:	
Return By:	
Patient Name:	
MRN:	

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.

To submit your application by mail:

Gillette Children's Specialty Healthcare

Attn: Revenue Cycle – GAP

Internal Zip: #010609

200 University Ave. E

St. Paul, MN 55101

To submit your application by fax: (651-325-2174) or email: financialassistance@gillettechildrens.com

If you have questions – please contact a Financial Advocate at 651-325-2235

BEFORE YOU SUBMIT YOUR APPLICATION
✓ Sign and date application
✓ Include a copy of your most recent federal income tax return
Black out ANY and ALL Social Security Numbers and Bank Account Numbers

**Income statements, bank statements, or other proof of income statements may be considered in lieu of a tax return*

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 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 appropriate Federal and State employment and income history or prior year W2. 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 (ie, 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 (if applicable) _____Date _____

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:	

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**