Swift County-Benson Health Services
Financial Assistance Application

Applicant/Responsibility Party: ____________________ ____________________ ____
Last Name First Name MI

Patient Name: ____________________ ____________________ ____
Last Name First Name MI

Applicant Address: ____

City: ____________________ **State:** __________ **Zip Code:** __________

Home Phone: ____________________ **Work Phone:** ____________________

Email Address: ____

Has Applicant applied for Medical Assistance? ☐ Yes ☐ No
Is Applicant ineligible for Medical Assistance? ☐ Yes ☐ No

****** If ineligible, Please attach a copy of the denial letter with this application.**

CALCULATION OF EXEMPTIONS

Family Size: ______________

List the names of all members of your family and relationship (including applicant's name):

Name(s)	Relationship

INCOME INFORMATION

A. **Employment:**
Applicant's Social Security #: ________________ Employer: ____________________

Spouse's Social Security #: ________________ Employer: ____________________

B. **Income:**

1. Please submit a copy of last year's tax return. (skip step 2 if you submit your tax return)
2. If there have been life events you've experienced and a tax return wouldn't represent your situation OR you don't have a tax return, please complete the following table and attach proof of income:

Income Source per month	**Applicant**	**Spouse**	**TOTAL INCOME:**
Employment (Gross Amount)			
Interest Income			
Social Security/SSI			
Disability			
Unemployment Compensation			
Worker's Compensation			
Pension(s)			
Child Support			
Alimony			
Public Assistance			
Military Pay			
Other:			
Other:			
TOTAL INCOME:			

I understand the information provided is subject to verification. I certify that the information on this application is true and correct to the best of my knowledge. I agree to notify this organization promptly of any changes to the information in this document.

Applicant's Signature: ___________________________________ Date: ___________

Return Completed application and requested information to:
Swift County-Benson Health Services
Business Office Manager
1815 Wisconsin Avenue
Benson, MN 56215
Call 320-843-4232 with questions – ask for the Business Office.

FOR OFFICE USE ONLY:

Date Application Received:	
Income Verified: YES / NO	**% of Discount:**
Denied: YES / NO	**Reason for Denial:**
Date of Determination:	**Date Applicant Notified:**

Approved by/Signature of SCBHS Staff: ____

Swift County-Benson Health Services
Requirements for Financial Disclosure

The following checklist of requested documents will assist in completing the application and meet financial disclosure requirements.

1. Application Form:
    a. Must be complete and returned.

2. Income Verification:
    a. All Income Sources: (Applicant and Spouse)
        i. Copy of last year's tax return
        ii. Copy of Proof of Income

3. Number of exemptions as determined on tax return.

4. Medical Assistance (MA):
    a. Contact Swift County Human Services to apply for Medical Assistance.
        i. Address: 410 21st Street South, Benson, MN 56215
        ii. Phone number: 320-843-3160
    b. Send copies of MA determination letter with application (denial or eligibility letters).

Note: Failure to submit requested information may result in automatic denial of Swift County-Benson Health Services Financial Assistance.