Please return by:

P O BOX A
200 ELM ST N.
ONAMIA MN 56359
320-532-2655 or 320-532-2651

FINANCIAL ASSISTANCE APPLICATION

Guarantor's #__________

NAME: ____

ADDRESS: ____

____

HOME PHONE: ____________________ **WORK:** ____________________

FAMILY INFORMATION: Please list name and age of all persons living in household. If persons are over 18 please indicate if student and/or working.

NAME	RELATIONSHIP	DATE OF BIRTH

INCOME INFORMATION:

Please provide a copy of the most current Tax Return and 2 months most recent pay stubs, social security, pension, child support, or any other income for all household income earners.

Employer: __________________________________ **Start date:** _________________________

Monthly Income: $_____________

Spouse's Employer: _________________________ **Start date:** _________________________

Monthly Income: $_____________

Other Monthly income:

Unemployement income:	**$**__________	**Social Security/VA:**	**$**_____________
Pension/Retirement:	**$**__________	**Child/Spousal support:**	**$** _____________
County/Government:	**$**__________	**Tribal Benefits:**	**$**_____________
HSA/HRA, Flex:	**$**__________	**Other:**	**$**_____________

Have you applied for MN State health plans with your county? Yes___ No___(please check one)

If No, you must apply or call us for qualification requirements.

If Yes, what was the outcome? (If denied, attach copy of denial)___________________

We will not consider incomplete applications, but will notify applicants by phone or mail of an incomplete application and provide you an opportunity to send in the missing documentation or information within 30 days from the date of notification.

The information above is correct to the best of my knowledge. If any details are false, MLHS has the option to terminate any discounts provided.

Signature: ____ **Date:** ___________

Signature: ____ **Date:** ___________