



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

Please return by: _____

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 of 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:

Unemployment income: \$ _____	Social Security/VA: \$ _____
Pension/Retirement: \$ _____	Child/Spousal support: \$ _____
County/Government: \$ _____	Tribal Benefits: \$ _____
HSA/HRA, Flex: \$ _____	Other: \$ _____

Have you applied for Medical Assistance 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) _____

It is required that you provide a copy of your two most recent bank statements.

CHECKING ACCOUNT \$ _____ SAVINGS ACCOUNT: \$ _____ CDs & IRAs: \$ _____

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: _____