

## Financial Statement

## For Internal Use Only

Name	Site Issued	MPII/CMRN Number
ID Number	Date Issued (Month DD, YYYY)	Issued By

Instructions: Complete application and attach copies of:

- Tax returns and supporting schedules (previous 2 years)
- Social Security benefits
- Provide a written explanation describing your need for financial assistance Note: if additional space is needed, attach additional sheets
- Pay stubs (most recent 3 months)
- Bank statements (most recent 3 months for all accounts)
- W-2's or Unemployment Statement

I have applied for or will apply for medical assis	tance.					
□ Yes □ No Reason						
I have a lawsuit, settlement, personal injury, or liability claim pending.						
☐ Yes ☐ No Reason	□ Yes □ No Reason					
I have the availability of insurance through my e	mployer or my spouse's emplo	oyer.				
☐ Yes ☐ No Reason						
I have previously applied for financial assistance						
☐ Yes ☐ No ☐ Not Sure						
Where		When				
Responsible Party/Patient	1		1.1			
Name		Social Security Number	er	Birth Date (Month DD, YYYY)		
Address						
				T		
City		State		ZIP Code		
	T .					
Phone	Household Size (Patient, Spouse and Dependents)	Marital Status	'	u claimed on another tax return?		
			□Yes	□ No		
Student	School					
☐ Full-Time Student ☐ Part-Time Student	Contool					
Employment Status Employer Name						
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed						
Employer Address			Employer Phone			
City		State		ZIP Code		
Job Title	E	imployment Length	Unemp	oloyed Date/Length (Month DD, YYYY)		

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ID Number		Date Issued (Mon		Issued (Monti	h DD, YYYY)	Issued By	
Spouse/Partne	er						
Name					Social Security Nur	mber	Birth Date (Month DD, YYYY)
Sahaal			Full Tie	ne Student	Phone		
School				me Student me Student	Priorie		
Employment Status		<u> </u>		Employer Na	ime		
	art Time 🔲 Self Em	ployed 🗆 Unemployed					
Employer Address							Employer Phone
City					State		ZIP Code
org					Guato	ľ	-11 0000
Job Title				Employment	Length	Unemployed	d Date/Length (Month DD, YYYY)
Dependents							
Full Name					Relationship		Birth Date (Month DD, YYYY)
<b>Bank Account</b>	Balances	,		,			
Bank Name		Bank Address			Account Type		Account Balance
					Checking		+
					Savings		
					Other Investments a	na Securities	
		l					
Property Indicate	all property and asse	ts that you own, including a	all recre	eation vehicle	es, etc.		
Туре	Detail				Estimated Value		Unpaid Balance
Residence							
Vehicles	Type/Year/Make						
Vehicles	Type/Year/Make						
Vehicles	Type/Year/Make						
Land  Rental Property	Number of Acres						
Rental Property Business							
Other							

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Name		Site Issued		MPII/CMF	RN Number	
ID Number Date Issued		Date Issued (Mo	(Month DD, YYYY) Is		ssued By	
Household Income						
Income Description			Source		Monthly Income Amount	
Responsible Party/Patient						
Spouse/Partner						
Interest/Dividends						
Stocks/Bonds						
Pension						
Rental/Property						
Disability						
Alimony/Child Support						
Other						
Insurance Indicate all typ	es of insurance policies you curr	ently hold, e.g., health, li	fe. auto. etc.			
Туре	Policy With	,,,			<b>Monthly Payment</b>	
Health						
Auto						
Life						
Home Owners/Renters						
Other						
Monthly Expenses Inc Expense Description	dicate your average monthly hous	sehold expenses, e.g., gr	oceries, utilities, me	edications, etc.	Average Expense	
Rent					Attituge Expense	
Groceries						
Utilities						
Auto (gas/repairs)						
Phone						
Mobile Phone						
Cable/Internet						
Entertainment						
Clothing						
Childcare						
Child Support						
Alimony						

Medications

Other

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Туре	To Whom	Unpaid Balance	<b>Monthly Payment</b>
Mortgage			
Home Equity			
Personal Loan			
School Loan			
Vehicle Loan			
Vehicle Loan			
Credit Card			
Medical: Doctor			
Medical: Doctor			
Medical: Hospital			
Medical: Hospital			
Other			
Other			
		Total Monthly Incor	ne
		Total Monthly Expens	es
		Income Less Expens	es

## Certification

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Mayo Clinic or an affiliated entity and I give permission to Mayo Clinic and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Mayo Clinic, all Mayo Clinic affiliates and representatives or agents to investigate the information contained herein, and to obtain credit reports.

Patient/Responsible Party Signature	Date (Month DD, YYYY)
Spouse/Partner Signature	Date (Month DD, YYYY)

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