FINANCIAL ASSISTANCE APPLICATION

At Trinity Health, we recognize that medical expenses can be difficult to manage. Our Financial Counselors are available to answer questions and assist with the financial assistance application process. Our priority is to ensure all patients have access to medically necessary care, regardless of financial circumstances.

If assistance is needed at any time during the application process, please contact us Monday through Friday, 8:00 a.m. to 4:30 p.m. CST at **701-857-5105**, or by email at **bsfincounselors@trinityhealth.org**. In-person support is also available at the Patient Financial Services office, **2305 37th Ave SW, Minot, ND 58701**.

To process your application, please submit a completed Financial Assistance application along with the following documentation:

Photo Identification for all applicants over 18:
(unexpired) Driver's License or State ID, Military ID, Permanent Resident Card, or Passport.

Proof of Residency (ND or Northeastern MT):
Lease or mortgage agreement, property tax bill, or a current utility bill for electric, gas, or water.
Note: Cell phone bills, medical bills, bank statements, and credit card statements cannot be accepted.

Medicaid Documentation (if applicable):
North Dakota Medicaid approval or denial letter.

Proof of Household Income:
Recent or final pay stubs; documentation of income from Social Security, retirement, Veteran's benefits, unemployment, workers' compensation, disability, alimony, or child support; and any additional income such as dividends, interest, rents, royalties, annuities, estates, trusts, inheritance, or non-repayable student aid.

Most recent federal tax return with all schedules

Proof of Assets:
Two months of statements for all checking, savings, and investment accounts. List of secured assets with current value and loan information, including home, additional vehicles, recreational vehicles, land, or vacation property.

If any information is missing, Trinity Health will contact you to request the additional documentation. Please return requested items within 14 days so the review can be completed. Applications may be denied if required information is not received; however, they may be reconsidered once all documentation has been provided.

Thank you for your cooperation.

Trinity Health – Patient Financial Services

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Applicant's Name:______________________ Date of Birth:__________ Cell Phone:__________

Address:______________________ City:__________ State:__________ Zip:______

Employer:______________________ Occupation:______________________

Start Date:______________________ Previous Employer:______________________

Co-Applicant's Name:______________________ Date of Birth:__________ Cell Phone:__________

Co-Applicant's Employer:______________________ Occupation:______________________

Start Date:______________________ Previous Employer:______________________

Please list all dependents under the age of 18 living in your household.

Name:______________ Date of Birth :________ Name:______________ Date of Birth :________

Name:______________ Date of Birth :________ Name:______________ Date of Birth :________

Name:______________ Date of Birth :________ Name:______________ Date of Birth :________

Number of people in household:______

Rent, Lot Rent, or House Payment: $________

Have you applied for Medicaid? ☐ Yes ☐ No

If Yes: Application Date:______________________ Check one: ☐ Approved ☐ Denied

If denied, list reason for denial:______________________

Assets	Year	Description	Value	Balance Owing	Payment Amount
House					
Vehicle					
Vehicle					
Boat					
RV/Camper					
Rec. Vehicle					
Other*					

*Investments, Stocks, Bonds

Account Type	Account Number	Financial Institution	Account Holder's Name
Checking Account			
Savings Account			
Checking Account			
Savings Account			

Monthly Income	Applicant	Co-Applicant
	$	$
Gross Wages	Monthly: ___Weekly: ___Biweekly: ___	Monthly: ___Weekly: ___Biweekly: ___
Self-Employment	$	$
Unemployment	$	$
Social Security/SSI/SSD	$	$
Retirement Benefits/Railroad Retirement	$	$
Child Support/Alimony	$	$
Rental Income/Royalties/Trusts/Estates	$	$
Miscellaneous/Family Member Assistance	$	$

Any other information you would like to include for us to take into consideration:____

I certify the above information is true and correct. I understand that the purpose of this information is to assist Trinity Health in determining my eligibility for assistance and in finding an acceptable payment plan. I authorize Trinity Health to contact the employers and institutions on this application to verify its accuracy. I further authorize the employers/institutions to release such information to Trinity Health.

Signature ______________________ Date ______________