

Financial Assistance Application

Diabetes Center

Name:			Age:	
City:		State:	Zip:	
Phone:			DOB:	
What type of assistance	are you seekin	g (check all that apply)		
Clinic visit with	n a nurse educa	tor		
Clinic visit with	dietitian			
Clinic visit with	nurse practitio	ner and/or physician		
Pharmacy ass	istance			
Travel to Gran	d Forks			
Your application must i direct deposit, Social S	•		order to be processed (i.e. paycheck,	
Provide proof of income of	documentation	including:		
Wages:	\$	/month		
Social Security:	\$	/month		
Disability:	\$	/month		
Rental Income:	\$	/month		
Income Guidelines (can these in the comment line		amount unless you have ext	enuating circumstances) please mention	
Household	<u>Number</u>	Income Yearly	Gross Income Monthly	
1		\$33,510	\$2,793	
2		\$45,510	\$3,783	
3		\$57,270	\$4,773	
4		\$69,150	\$5,763	
5		\$81,030	\$6,753	
6		\$92,910	\$7,743	
Comments: Please shar	e any other info	ormation that would substantia	ate your eligibility:	
	_	escind scholarship funding ats and/or not following pro	-	
Patient Signature:			Date:	

THIS PORTION TO BE COMPLETED BY STAFF MEMBER

Diagnosis:		
Date of patient visit:		
Eligibility requirements met:		
Comments:		

Altru Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. For more information, see link on our website at altru.org. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.732.4277. ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.732.4277. LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.732.4277.