Financial Assistance Application

Diabetes Center and Weight Management Program

Name:_____ Age: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ DOB: _____

What type of assistance are you seeking (check all that apply)

____ Clinic visit with a nurse educator

____ Clinic visit with dietitian

____ Clinic visit with nurse practitioner and/or physician
Weight Management (medical necessity - showing proof of diagnosis of diabetes or prediabetes)

____ Pharmacy assistance

____ Travel to Grand Forks

Your application must include proof of income documentation in order to be processed (i.e. paycheck, direct deposit, Social Security award letter, etc.)

Provide proof of income documentation including:

Wages: $ _____ /month

Social Security: $ _____ /month

Disability: $ _____ /month

Rental Income: $ _____/month

Income Guidelines (cannot exceed this amount unless you have extenuating circumstances) please mention these in the comment lines.

Household Number	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 share any other information that would substantiate your eligibility:

Patient Signature: _____Date: _____

THIS PORTION TO BE COMPLETED BY STAFF MEMBER

Diagnosis: _____

Date of patient visit:_____

Eligibility requirements met: _____

Comments: _____

_____

_____

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