



Financial Assistance Application

Diabetes Center

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
- 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.

<u>Household Number</u>	<u>Income Yearly</u>	<u>Gross Income Monthly</u>
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:

We reserve the right to rescind scholarship funding if you do not show up for scheduled appointments and/or not following provider recommendations.

Patient Signature: _____ Date: _____

THIS PORTION TO BE COMPLETED BY STAFF MEMBER

Diagnosis: _____

Date of patient visit: _____

Eligibility requirements met: _____

Comments: _____
