

Financial Assistance Application

Diabetes Center

Name:			Age:	
			Zip:	
Phone:			DOB:	
What type of assistance	are you seekin	g (check all that apply)		
Clinic visit with	n a nurse educa	ator		
Clinic visit with	n dietitian			
Clinic visit with	n nurse practitio	oner 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	documentation	including:		
Wages:	\$	/month		
Social Security:	\$	/month		
Disability:	\$	/month		
Rental Income:	\$	/month		
Income Guidelines (car these in the comment lin		s amount unless you have exte	enuating circumstances) please mention	
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 shar	re any other info	ormation that would substantia	ate your eligibility:	
	•	rescind scholarship funding nts and/or not following prov	•	
Patient Signature:			Date:	

THIS PORTION TO BE COMPLETED BY STAFF MEMBER

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

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