Financial Assistance

Application Information

Essentia Health has a Financial Assistance Program that may help you with your medical bills.

When you fill out the application, it will help us see if you are eligible for free or discounted care. If your application is approved, you will have financial assistance for 12 months from the approval date.

Return your completed, signed application and any supporting documents to:

Essentia Health
Attn: BSC – Financial Assistance
420 E 1st Street
Duluth, MN 55805

Or scan your paperwork and email:
financialassistanceappinfo@essentiahealth.org

You can also apply for Financial Assistance through your MyChart account.

We're here to help

It is our practice to help patients complete the financial application. This includes where barriers are identified.

If you have any questions or need help filling out the form, please call our Patient Financial Services Department at **1-800-985-4675**.

Please provide the following information with your application.

Taxes

- Current filing year of your federal tax return such as Form 1040. Please also include any related tax schedules such as forms 1, C, E, F or SE.

Wages

- Your last 2 full months (60 days) of employment pay stubs.

Other Income

- Social Security Income
- Workers' Compensation, Disability Insurance Payments or Unemployment Insurance
- Spousal Maintenance Income and/or Child Support Income
- Pension, Annuity, VA benefit payments
- Retirement Accounts (IRA, 401k, etc.)
- Tribal income, rental income, interest income, dividends or royalties

We require a copy of your 2 most recent bank statements. The statements need to show deposits of your income from the list above.

Essentia Health®

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Essentia Health

Financial Assistance Application

Check each box for where you have medical bills from:

- ❑ Essentia Health
- ❑ Essentia Health Ambulance
- ❑ Other_____

Complete all the fields. This will ensure your application is processed in a timely manner.
Enter **n/a** (**not applicable**) if a field does not apply to you.

Applicant Name: _____ Date of birth: _____

Phone number: _____ Guarantor number: _____

Address: _____ City: _____

County: _____ State: _____ Zip code: _____

Please list only the people who live in your household who are claimed as dependents on your taxes.

First and Last Name	Date of birth	Relationship to you	Does this person have Medical Assistance?

Do you have health insurance? ☐ **Yes** ☐ **No**

* You will need to apply for your state's Medicaid program if you do not have health insurance or if your family is within the Medicaid income guidelines. Note in Minnesota, Medicaid is also known as Medical Assistance.
* **You will need to include your Medicaid approval or denial letter. Or proof of your Medicaid application submission.**

I hereby request that Essentia Health determine my eligibility for the Essentia Health Financial Assistance Program. I acknowledge that the information provided in the application is true and correct. I understand that the information that I submit will be subject to verification by Essentia Health as an audited program. If any information is determined to be false, it will result in a denial of the financial assistance program. Failure to fully compete this application and provide supporting documents may result in denial of this application.

Applicant's signature: _____ **Date:** _____

Financial Assistance Check List:

- ❑ I have completed all fields on this Financial Assistance application.
- ❑ I have signed and dated my completed application.
- ❑ I have included all the required documents or a letter explaining why I am not able to submit the required documents.
- ❑ I understand my application can be denied if any required information is missing.