612 Center Avenue No.
P.O. Box 450
Ashley, ND 58413-0450
(701) 288-3433

Financial Assistance Application

Patient Information:

Applicants Name: _____

Address: _____

Phone #: _____

Date of Birth:_____

Employer: _____

Occupation: _____

Date of Service: _____

Household Information:

Estimated Annual Income: _____

Family Size (include self): _____

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Assets:
(Assets represent value of ownership that can be converted into cash. Ex- house, stocks/bonds, vehicle, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Cash (List amount of cash that is readily available. Ex- cash on hand, savings account, etc.):

$_____

Additional Comments:

_____

_____

_____

_____

_____

Ashley Ambulance is not covered under this policy.

Declaration:
I hereby acknowledge that the information provided in this application is true and correct, and authorize the release of information from financial institutions, creditors, and employers, to Ashley Medical Center for the purpose of verifying the accuracy of information provided in this application. All Alternative payment resources have been exhausted (including Medicaid, Medicare, Insurance, etc.). I will take any action reasonably necessary to obtain such assistance and will assign or pay to the Ashley Medical Center the amount recovered for charges.

Applicant's Signature:_____ Date:_____

*****Please include most recent tax return*****

For Hospital Use Only

Approved _____ Denied_____

Approved Amount: $_____

Applicant Amount: $_____

Monthly Amount: $_____

Comments: _____

Hospital Representative: _____

Date: _____

For assistance with this application please contact the Ashley Medical Center (612 Center Ave N, Ashley, ND 58413) or by calling 701-288-3433.