



财务援助申请表

Financial Assistance Application (Chinese)

Form content not retained in medical record.  
For local storage only.

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

服务地点  
Service Location

说明:填写申请表并附上以下材料的复印件:

Instructions: Complete application and attach copies of:

- 本年度或上一年度的纳税申报表 (如果无法提供纳税申报表, 请提供 W-2 表格)  
Tax return from current or prior year (or W-2 if tax not available)
- 失业声明 (如适用)  
Unemployment statements (if applicable)
- 工资单 (最近一个月)  
Pay stubs (most recent month)
- 社会保障金、养老金、退休福利 (如适用)  
Social security, pension, retirement benefits (if applicable)
- 银行对账单 (所有账户最近一个月的对账单)  
Bank statements (most recent month for all accounts)

如果无法提供上述复印件, 请另附一页以详细说明您当前的财务状况。  
If the above copies are not available, provide a separate page describing your current financial situation.

仅在威斯康星州 Mondovi 的 Oakridge 诊所或明尼苏达州 Albert Lea 行为健康中心就诊的患者, 只需填写申请表, 并附上以下任一文件的复印件:

Patients seen only at Oakridge in Mondovi, Wisconsin or Albert Lea, Minnesota Behavioral Health are only required to complete the application and attach copies of **one** of the following:

- 上一年度的 W-2 表格 (若未提交过 W-2 表, 则请提供 4506-T 表格)  
Prior year W-2 (or Form 4506-T if W-2 not filed)
- 最近两个月的工资单  
Two most recent pay stubs
- 雇主提供的收入证明  
Income verification from employer

填写此申请表的患者或责任方

Patient or Responsible Party Completing This Application

患者姓名 (名字 中间名 姓氏) Patient Name (First Middle Last)		出生日期 (月-日-年) Birth Date (mm-dd-yyyy)	
地址 Address	城市 City	州 State	邮政编码 ZIP Code
填写此申请表的责任方 (若非患者本人) (名字 中间名 姓氏) Responsible Party Completing the Application (if not the Patient) (First Middle Last)		与患者的关系 (若非患者本人) Relationship to the Patient (if not the Patient)	
家庭年收入 (如所得税申报表中所填报的收入) Household Annual Income (as reported on income tax filing)		家庭人数 (患者、配偶和所得税申报表中所填报的受抚养人) Household Size (patient, spouse, and dependents as reported on income tax filing)	
电话 Phone	医疗保险名称和保单号码 Medical Insurance Name and Policy Number		

财务援助申请表 (接上)

Financial Assistance Application (Chinese) (continued)

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic Number

就业状况 Employment Status	<input type="checkbox"/> 全职 Full time	<input type="checkbox"/> 兼职 Part time	<input type="checkbox"/> 自雇 Self employed	雇主名称 Employer Name
	<input type="checkbox"/> 失业 Unemployed	<input type="checkbox"/> 学生 Student	<input type="checkbox"/> 退休 Retired	
就业时长 Employment Length	失业日期/时长 (月-日-年) Unemployed Date/Length (mm-dd-yyyy)			其他纳税申报表上是否有您的申报内容? Are you claimed on another tax return?
				<input type="checkbox"/> 是 <input type="checkbox"/> 否 (如果“是”, 请提供相关纳税申报表。) Yes                      No (If “Yes,” provide tax return.)

受抚养人 (若受抚养人数超过 6 人, 请另行附加页面填写)

Dependents (If more than 6 dependents, use separate page)

全名 (名字 中间名 姓氏) Full Name (First Middle Last)	关系 Relationship	出生日期 (月-日-年) Birth Date (mm-dd-yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

仅在威斯康星州 Mondovi 的 Oakridge 诊所或明尼苏达州 Albert Lea 行为健康中心就诊的患者, 无需填写以下与配偶相关的内容:

Patients seen only at Oakridge in Mondovi, Wisconsin or Albert Lea, Minnesota Behavioral Health do not need to complete the following spouse section:

配偶 (用于识别所有符合财务援助资格的患者账户)

Spouse (Used to identify all patient accounts eligible for financial assistance)

婚姻状况 Marital Status				
姓名 (名字 中间名 姓氏) Name (First Middle Last)				出生日期 (月-日-年) Birth Date (mm-dd-yyyy)
就业状况 Employment Status	<input type="checkbox"/> 全职 Full time	<input type="checkbox"/> 兼职 Part time	<input type="checkbox"/> 自雇 Self employed	雇主名称 Employer Name
	<input type="checkbox"/> 失业 Unemployed	<input type="checkbox"/> 学生 Student	<input type="checkbox"/> 退休 Retired	
就业时长 Employment Length	失业日期/时长 (月-日-年) Unemployed Date/Length (mm-dd-yyyy)			

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认证签名

Certification Signatures

本人特此证明, 基于本人所知, 本申请表中所填写的所有信息均真实准确。本人理解, 上述所提供的信息将用于确定本人是否具备支付妙佑医疗国际或其附属机构所提供的服务费用的能力。同时, 本人同意妙佑医疗国际及其所有附属诊所、医院和实体在处理本人财务援助申请的过程中, 可根据需要共享上述信息。本人特此授权妙佑医疗国际、其所有附属机构及其代表或代理人, 对本申请中所包含的信息进行核查。

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Mayo Clinic or an affiliated entity and I give permission to Mayo Clinic and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Mayo Clinic, all Mayo Clinic affiliates and representatives or agents to investigate the information contained herein.

患者或责任方签名 Patient or Responsible Party Signature	日期 (月-日-年) Date (mm-dd-yyyy)
责任方印刷体姓名 (名字 中间名 姓氏) Responsible Party Printed Name (First Middle Last)	