

## HealthPartners Family of Care

### Financial Assistance Application

Please answer each question as completely as possible. We will contact you if additional information or documents are required. **A copy of your most recent federal tax return and two most recent paycheck stubs for each household income earner must be returned with this application.** Please reference the attached information sheet for any additional documentation that is required.

Date of Application: \_\_\_\_\_

1. Name: \_\_\_\_\_

2. Patient Name (if under 18 years old): \_\_\_\_\_

3. Social Security: # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. Street/Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

6. Telephone (home): \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

7. Current Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other (please specify) \_\_\_\_\_

8. Spouse/Significant Other Name: \_\_\_\_\_

9. Spouse/Significant Other Address (if different than patient): \_\_\_\_\_

10. Spouse/Significant Other Social Security: # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

11. Spouse/Significant Other Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

12. Names and ages of household members:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Do you have insurance to cover medical expenses? \_\_\_\_\_ (Y/N) Monthly premium: \$ \_\_\_\_\_

Health insurance company name: \_\_\_\_\_

14. In relation to your medical bills, do you have a lawsuit or insurance claim because of an accident or injury? \_\_\_\_\_ (Y/N)

If yes, Name and Telephone number of your Attorney: \_\_\_\_\_

15. Current Employment status: Full time \_\_\_ Part-time \_\_\_ Laid off \_\_\_ Other (please specify) \_\_\_\_\_

Please complete with information of the current or most recent employer and wages

16. Place of employment: \_\_\_\_\_

Address of employment: \_\_\_\_\_

Hourly Wage \$ \_\_\_\_\_ or Monthly Wage \$ \_\_\_\_\_ Hours per Week \_\_\_\_\_

17. Spouse/Significant Other employment status: Full time \_\_\_ Part-time \_\_\_ Laid off \_\_\_ Other (please specify): \_\_\_\_\_

Please complete with information of the current or most recent employer and wages

18. Spouse/Significant Other place of employment: \_\_\_\_\_

Spouse/Significant Other address of employment: \_\_\_\_\_

Spouse/Significant Other: Hourly Wage \$ \_\_\_\_\_ or Monthly Wage \$ \_\_\_\_\_ Hours per Week \_\_\_\_\_

19. List other sources of income (per month):

(Alimony, Child Support, Interest/Dividends, Social Security of Disability, Unemployment, Farm or Self-Employment, etc...):

_____	\$	_____	\$
_____	\$	_____	\$
_____	\$	_____	\$

20. I/we own the following motor vehicles:

Name of owners	Make	Model	Year	Value	Amount owed	Monthly payment
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

21. Auto Insurance company name: \_\_\_\_\_ Monthly premium: \$ \_\_\_\_\_

22. List recreational vehicles boats, campers, snowmobiles, etc.:

Name of owners	Make	Model	Year	Value	Amount owed	Monthly payment
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

23. Other Assets owned:

Estimated Value	Amount Owed	Monthly Payment	Financial Institution
_____	_____	_____	_____
_____	_____	_____	_____

24. Where do you bank? \_\_\_\_\_

Balances: Checking: \$ \_\_\_\_\_ Savings: \$ \_\_\_\_\_

25. Other Assets: Cash on hand: \$ \_\_\_\_\_ CD's \$ \_\_\_\_\_ Stocks/bonds: \$ \_\_\_\_\_ IRA's: \$ \_\_\_\_\_

26. Buying or renting your home: \_\_\_\_\_ How long have you lived at this address: \_\_\_\_\_

27. Monthly Rent: \$ \_\_\_\_\_ Monthly Mortgage: \$ \_\_\_\_\_

28. If you own, what is your primary residence assessed taxable value: \$ \_\_\_\_\_ Amount owed: \$ \_\_\_\_\_

29. Do you own other real estate: \_\_\_\_ (Y/N) If yes, what is the value? \$ \_\_\_\_\_

30. Utility costs per month: Gas: \$ \_\_\_\_\_ Electric: \$ \_\_\_\_\_ Water/Sewer: \$ \_\_\_\_\_ Telephone: \$ \_\_\_\_\_

31. Other monthly expenses/liabilities (e.g. medical bills, child support, alimony, daycare, real estate tax, pharmacy, medical supplies etc.):

_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

32. Based on the information provided on this application, I can afford a monthly payment of \$ \_\_\_\_\_ on my account(s).

For purposes of this form, "HealthPartners" means HealthPartners Medical Group, Regions Hospital, Hudson Hospital & Clinics, Westfields Hospital & Clinic, Lakeview Hospital, Amery Hospital & Clinic and any other entity that provides services at a HealthPartners family location.

I understand that the information which I have provided is subject to verification by HealthPartners, to review by federal and state agencies, and for other programs or related purposes. I also understand that my application and eligibility for financial assistance is subject to the guidelines of the HealthPartners entity from which I received my care. I certify that the above information is true and correct.

I/We hereby authorize HealthPartners to review federal and state records of employment and income history, including State Employment Security Agency records. I/WE also authorize HealthPartners to obtain a credit report through an authorized credit bureau. This authorization is in effect for one (1) year unless limited by state law. A photographic or carbon copy of the authorization (of the signatures(s) of the undersigned) may be accepted as the original and may be used as a duplicate original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse/Significant Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY:**

Account # \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Total Charges \_\_\_\_\_ Type of Service (inpt/outpt/other) \_\_\_\_\_