HealthPartners

HealthPartners Family of Care

Amery Hospital & Clinic 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. Buying or renting your home: ____________________ How long have you lived at this address: ____________________

21. Monthly Rent: $ ______________________Monthly Mortgage: $____

22. Utility costs per month: Gas: $__________ Electric: $__________ Water/Sewer: $__________Telephone: $__________

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

____________________________ $____________________ _________________________ $__________________

____________________________ $____________________ _________________________ $__________________

24. 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 Amery Hospital & Clinic, 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 Amery Hospital & Clinic 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)_________________________