



If you have questions about this application please contact Patient Accounting at 651-265-1999 (or toll-free at 1-877-655-2669).

**Medical Group & Clinics
Financial Assistance Program Application**

Name		Home Phone	HealthPartners Account #	
Address		City	State	Zip
Date of Birth	Marital Status	Spouse's/Other household adult's name(s)		
Applicant		Other Household Adults		
Employer		Employer		
Employment (FT / PT, Salaried /Hourly) # of hrs/wk?		Employment (FT / PT), Salaried /Hourly # of hrs/wk?		
Dependents (Total Household Dependents)				
Dependents (How many claimed on taxes?)	Name(s)	Date(s) of Birth		
Income and Assets				
Income (list all household income) <i>A copy of your most recent income tax return (with attachments) and 2 months of pay check stubs must be returned with this application.</i>	Monthly Income Self	Monthly Income Spouse/Other household adults	Assets (what you own):	
Wages and tips (Gross)	\$	\$	Savings Account(s)	\$
Public assistance	\$	\$	Checking Account(s)	\$
Social security and disability (Gross)	\$	\$	Stocks/Bonds	\$
Unemployment	\$	\$	C.D(s)	\$
Income from annuities, investments, dividends	\$	\$	Money Market Accts	\$
Other	\$	\$	Other	\$
Total	\$	\$	Total	\$
Insurance information				
Do you have insurance to cover medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Notify our office of any insurance changes.		
Primary				
Name of insurance company	Effective date	Policy number	Group number	
Secondary				
Name of insurance company	Effective date	Policy number	Group number	
Read and Sign				
I acknowledge that the information on this application is true and correct to the best of my knowledge, and I hereby authorize HealthPartners to release this information to any physician, clinic, and/or other area hospital or clinic to which I am referred. I will notify Health Partners of any material changes in the statements provided on this form. I understand that this financial statement is to retain financial assistance and a credit bureau check will be obtained to verify eligibility. It will be treated as confidential information. I also acknowledge that I must enroll in and fully utilize and comply with (1) any Minnesota Health Care programs that I may qualify for or (2) any medical insurance that may be available to me through an employer and that failure to do so could result in removal from the HealthPartners Financial Assistance Program.				
Signature		Date		

Return completed application and information to:

HealthPartners Medical Group & Clinics
Patient Accounting
Mail Stop: 25508B
P.O. Box 244
Minneapolis, MN 55440-1309