HealthPartners®

Financial Assistance Application

Please Attach Paycheck Stubs AND 1040 Form from last Tax Return

Name	Date of birth	Phone	
Address	City	State	Zip
Marital Status ☐ Single ☐ Divorced ☐ Widowed (check one) ☐ Married ☐ Legally separated	Spouse's name		Date of birth

Dependents claimed on your Federal taxes

Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship
Name	Date of birth	Relationship

Insurance Information

Do you have current insurance to cover medical expenses? ☐ Yes ☐ No Notify our office of any insurance changes.

Have you applied for Medical Assistance/BadgerCare/Minnesota HealthCare Programs? ☐ Yes ☐ No
If you have no insurance you must apply for Medical Assistance/BadgerCare/MHCP before being approved for Financial Assistance.

Primary Insurance		Secondary Insurance	
Name of insurance company		Name of insurance company	
Effective date	Group Number	Effective date	Group Number
Policy Number		Policy Number	

Income Information: include information for all household earners

Type	Annual Income (or wage and hrs/wk)	Type	Annual Income
Wages (self)	$	Pensions	$
Wages (spouse)	$	Unemployment	$
Social Security	$	Alimony	$
Public Assistance	$	Child Support	$

Other (Please explain):

Employment Information

Employer Name	Employer Phone
Employer Address	
Employer Name	Employer Phone
Employer Address	

Assets & Liabilities

Motor/Recreational vehicles	Make/Model/Year	Value	Amount owed	Monthly payment
		$	$	$

Updated: 10/19/2017

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		$	$	$		
		$	$	$		
		$	$	$		
Other Assets Owned	**Estimated Value**	**Amount Owed**	**Monthly Payment**	**Financial Institution**		
	$	$	$			
	$	$	$			
Bank Information	**Checking Balance**	**Savings Balance**	**CDs**	**Stocks/bonds**	**Cash**	**IRAs**
	$	$	$	$	$	$
	$	$	$	$	$	$

Do you buy or rent your home?		**How long have you lived there?**		
Monthly Rent: $		Monthly Mortgage: $		
If you own, assessed taxable value $		Amount owed:$		
Do you own other real estate?		Value of other real estate: $		
Monthly utility costs	Gas: $	Electric: $	Water: $	Phone:$
Other monthly expenses/liabilities:		**Cost:**		
		$		
		$		
		$		

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

I understand that the information I have provided is subject to verification by HealthPartners, for 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: _____