Northfield Hospital + Clinics

Application for Financial Assistance

Patient's name: _____ Date of application: _____

Account number: _____

Date(s) of service: _____

Please note: The following information will be used in determining eligibility for financial assistance. All information that you provide will be held in confidence.

Name *(last, first, middle initial):* _____

Address *(street address, city, state, zip):* _____

Phone number: _____ Length of time at current residence: _____

Date of birth: _____ Social Security Number: _____

Name of employer: _____ Employer's phone number: _____

Employer's address *(street, city, state, zip):* _____

If you have any questions about completing this form, please call (507) 646-1399 for assistance. Northfield Hospital will make a determination of eligibility for financial assistance within fifteen (15) working days after receiving the completed application form.

Required attachments:

❒ Medical Assistance denial / approval

❒ Last 3 current pay stubs for patient, parent and/or spouse

Northfield Hospital + Clinics

Application for Financial Assistance

Northfield Hospital + Clinics offers all patients an opportunity to apply for financial assistance for medical services provided and billed by our organization.

Requirements for eligibility:
The patient must have previously applied for Medical Assistance and must provide written proof of denial. This denial will be used in the determination process.

Income:
Income must meet the following guidelines:

2024 Federal Poverty Guidelines - Annual Income			
Family Size	**100%**	**200%**	**300%**
1	$15,060	$30,120	$45,180
2	$20,440	$40,880	$61,320
3	$25,820	$51,640	$77,460
4	$31,200	$62,400	$93,600
5	$36,560	$73,160	$109,740
6	$41,960	$83,920	$125,880
7	$47,340	$94,680	$142,020
8	$52,720	$105,440	$158,160

Income Guidelines for Financial Assistance

1. For families with more than 8 members, add $5,380.00 for each additional person.
2. Income levels below 200% of Federal Poverty Guidelines will be eligible for 100% financial assistance, if all other requirements are met.
3. Income levels below 200% to 300% of the Federal Poverty Guidelines will be eligible for a 50% discount, if all other requirements are met.

Note: Figures current as of 1/2024

Please complete if you have any of the items listed below.

	Yes/No	Owner's Name	Value	Amount Owed
Real Estate (other than home)				
Checking Account				
Savings Account				
Stocks/Bonds				
Motor Vehicle (if more than one)				
Boat, Motorcycle, Camper				
Other				
Total Value				

(continued, over...)

Members of Household:

Please enter the names, ages, and relationships of all family members who live with you:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCOME STATEMENT

Average monthly gross income ..... $ _____

1) From employer ..... $ _____

2) Self-employment

a) Farming ..... $ _____ per month

b) Business ..... $ _____ per month

3) Court-ordered support

a) Child / dependent ..... $ _____ per month

b) Other ..... $ _____ per month

3) Unemployment/Work Comp income ..... $ _____ per month

4) Miscellaneous other income ..... $ _____ per month

All of the information contained within this application form is true and accurate, to the best of my knowledge.

Applicant's signature: _____ Date: _____

After you have completed this form, please return it to:

Attention: Patient Financial Services
Northfield Hospital + Clinics
2000 North Avenue
Northfield, MN 55057-1697