Northfield Hospital + Clinics

Application for Financial Assistance

Patient's name: _____ Date of application: _____

Account number: _____

Date(s) of service: _____

Responsible person: _____

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 employee: _____ Employer's phone number: _____

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

Occupation: _____

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 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:

Income Guidelines for Financial Assistance

2023 Federal Poverty Guidelines – Annual Income

Family Size	100%	200%	300%
1	$14,580	$29,160	$43,740
2	$19,720	$39,440	$59,160
3	$24,860	$49,720	$74,580
4	$30,000	$60,000	$90,000
5	$35,140	$70,280	$105,420
6	$40,280	$80,560	$120,840
7	$45,420	$90,840	$136,260
8	$50,560	$101,120	$151,680

1. For families with more than 8 members, add $5,140.00 for each additional person.
2. Income levels below 200% for 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.

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

Real Estate (other than home): YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Checking Account: YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Savings Account: YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Stocks/Bonds: YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Motor Vehicle (if more than one): YES/NO
Owner's Name:_____Value:_____Amount Owed:_____
Boat, Motorcycle, Camper: YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Other: YES/NO
Owner's Name:_____Value:_____Amount Owed:_____

Total Value:
Owner's Name:_____Value:_____Amount Owed:_____

Members of the 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 $_____ per month

1. From employer $_____ per month
2. Self- employment
    a. Farming $_____ per month
    b. Business $_____ per month
3. Court-ordered support
    a. Child/dependent $_____ per month
    b. Other $_____ per month
    c. Unemployment/Work Comp income $_____ per month
    d. Miscellaneous other income $_____ per month

Other information that you wish to disclose for consideration of this application:_____

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 complete this form, please return it to:
Attention: Patient Financial Services
Northfield Hospital + Clinics
2000 North Avenue
Northfield, MN 55057-1697