

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 employer: _____ 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

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:

Income Guidelines for Financial Assistance			
2021 Federal Poverty Guidelines - Annual Income			
Family Size	100%	200%	300%
1	\$12,880	\$25,760	\$38,640
2	\$17,420	\$34,840	\$52,260
3	\$21,960	\$43,920	\$65,880
4	\$26,500	\$53,000	\$79,500
5	\$31,040	\$62,080	\$93,120
6	\$35,580	\$71,160	\$106,740
7	\$40,120	\$80,240	\$120,360
8	\$44,660	\$89,320	\$133,980

1. For families with more than 8 members, add \$4,540.00 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 1/2021

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

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

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

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