Hudson Hospital & Clinic

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Financial Assistance Application

Please answer each question as completely as possible. We will contact you if additional information or documents are required. **A copy of your most recent federal tax return and two most recent paycheck stubs must be returned with this application.** Please reference the attached information sheet for any additional documentation that is required.

Date of Application: _____

1. Name: _____
2. Patient Name (if under 18 years old):_____
3. Social Security: #_____-_____-_____
4. Date of Birth: _____/_____/_____
5. Street/Mailing Address: _____
   City: _____ State: _____ Zip: _____
6. Telephone (home): _____ (work) _____ (cell) _____
7. Current Marital Status: Single_____ Married_____ Other (please specify) _____
8. Spouse/Significant Other Name: _____
9. Spouse/Significant Other Address (if different than patient): _____
10. Spouse/Significant Other Social Security: #_____-_____-_____
11. Spouse/Significant Other Date of Birth: _____/_____/_____
12. Names and ages of household members:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

13. Do you have insurance to cover medical expenses? _____ (Y/N) Monthly premium: $_____
    Health insurance company name: _____
14. In relation to your medical bills, do you have a lawsuit or insurance claim because of an accident or injury? _____ (Y/N)
    If yes, Name and Telephone number of your Attorney: _____
15. Current Employment status: Full time ____ Part-time ____ Laid off ____ Other (please specify)_____

    Please complete with information of the current or most recent employer and wages

16. Place of employment: _____
    Address of employment: _____
    Hourly Wage $_____ or Monthly Wage $_____ Hours per Week _____
17. Spouse/Significant Other employment status: Full time ____ Part-time ____ Laid off ____ Other (please specify):_____

    Please complete with information of the current or most recent employer and wages

18. Spouse/Significant Other place of employment: _____
    Spouse/Significant Other address of employment: _____
    Spouse/Significant Other: Hourly Wage $_____or Monthly Wage $_____ Hours per Week_____
19. List other sources of income (per month):

(Alimony, Child Support, Interest/Dividends, Social Security of Disability, Unemployment, Farm or Self-Employment, etc…):

_____ $_____ _____ $_____

_____ $_____ _____ $_____

_____ $_____ _____ $_____

20. I/we own the following motor vehicles:

Name of owners	Make	Model	Year	Value	Amount owed	Monthly payment

21. Auto Insurance company name: _____ Monthly premium: $ _____

22. List recreational vehicles boats, campers, snowmobiles, etc.:

Name of owners	Make	Model	Year	Value	Amount owed	Monthly payment

23. Other Assets owned:

Estimated Value	Amount Owed	Monthly Payment	Financial Institution

24. Where do you bank? _____

Balances: Checking: $_____ Savings: $_____

25. Other Assets: Cash on hand: $_____ CD's $_____ Stocks/bonds: $_____ IRA's: $_____

26. Buying or renting your home: _____ How long have you lived at this address: _____

27. Monthly Rent: $ _____Monthly Mortgage: $_____

28. If you own, what is your primary residence assessed taxable value: $_____ Amount owed: $_____

29. Do you own other real estate: _____ (Y/N) If yes, what is the value? $ _____

30. Utility costs per month: Gas: $_____ Electric: $_____ Water/Sewer: $_____Telephone: $_____

31. Other monthly expenses/liabilities (e.g. medical bills, child support, alimony, daycare, real estate tax, pharmacy, medical supplies etc.):

_____ $_____ _____ $_____

_____ $_____ _____ $_____

32. Based on the information provided on this application, I can afford a monthly payment of $_____on my account(s).

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

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

OFFICE USE ONLY:

Account #_____ Date(s) of Service_____

Total Charges_____ Type of Service(inpt/outpt/other)_____