Request for Financial Assistance

Dear Patient and Family:

In keeping with its mission and core values, we are committed to providing health care for people regardless of their ability to pay.

Our Charity Care/Financial Assistance:
Medical bills may be difficult to pay. Patients who are unable to pay for all or part of their health care services may apply for financial assistance by completing and returning this form. Patients and families who meet certain income requirements may qualify for free care or reduced-price care based on their family size and income, even if you have health insurance.

What does financial assistance cover? Financial assistance covers medically necessary services provided by a United Hospital District provider, depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Our financial assistance policies, information about the programs, and application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Here's how to contact us:

www.uhd.org OR 507-526-3273 Monday - Friday 8:00am to 4:30pm

In order for your application to be processed, you must provide:

- □ **Information about your family**
  Fill in the number of family members in your household.
  Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. United Hospital District will also accept non-related household members when calculating family size.
- □ **Information about your family's gross monthly income** (income before taxes and deductions)
- □ **Attach additional information if needed**
- □ **Sign and date financial assistance form**

****Income Source Verification Required****

Applicants may provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may be used. Patients who are unable to provide written verification may provide a signed statement of income.

Mail completed application with all documentation to (be sure to keep a copy for yourself)**:**

United Hospital District and Clinics
Attention: Kathie Thom
P.O. Box 160
Blue Earth MN 56013

To submit your completed application in person: You may drop off your application at any UHD location.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

United Hospital District and Clinics
Financial Assistance Application
Confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name	Patient last name
Birth Date		
Person Responsible for Paying Bill		

Mailing Address
_____

_____
City State Zip Code

Main contact number(s)
( )_____
( )_____
Email Address:
_____

Employment status of person responsible for paying bill **(EMPLOYMENT INFORMATION - OPTIONAL)**

□ **Employed** (date of hire:_____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you.

FAMILY SIZE_____ *Attach additional page if needed*

Name	Date of Birth		If 18 years old or older - source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

Gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

Financial Assistance Application – Confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.
Examples of proof of income include:

- Gross wages; salaries; tips; income from business and self-employment;
- Unemployment compensation; workers' compensation; Social Security; Supplemental Security Income;
- Veterans' payments; survivor benefits; pension or retirement income;
- Interest; dividends; royalties; income from rental properties, estates, and trusts;
- Alimony; child support; assistance from outside the household; and other miscellaneous sources.
- A Signed Self Declaration of Income may be used if other income verification is not available.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

This information may only be used if your income is above 200% of the Federal Poverty Guidelines.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____
Insurance Premiums $_____ Utilities $_____
Other Debt/Expenses $_____(*child support, loans, medications, other*)

ADDITIONAL INFORMATION (Optional)

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that United Hospital District and Clinics may verify information in determining eligibility for financial assistance or payment plans.
I certify that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____
Signature of Person Applying Date