NORTH MEMORIAL HEALTH

MAPLE GROVE HOSPITAL

Guarantor / Account #:

Financial Assistance Application Instructions

Thank you for your interest in North Memorial Health's financial assistance program. This program provides financial assistance to qualified uninsured and underinsured customers for emergency and medically necessary services provided by a North Memorial Health (NMH) hospital and clinic facilities within the NMH system, including both facility and professional services offered by North Memorial Health Hospital, Maple Grove Hospital, NMH emergency transportation, and NMH hospice services. To be eligible for financial assistance you must submit a fully completed financial assistance application along with requested documentation, and:

- Balances must be within 365 days of the first post-discharge billing statement you received for that balance
- Have a *Family Income at or below 300% of the **Federal Poverty Level
- Apply for health insurance (Medical Assistance, MinnesotaCare) if it is determined you may be eligible
- Cooperate with NMH if your application is determined to be incomplete and additional information is needed

Family income will be determined by the most recent IRS tax filing year's tax returns of the Primary Applicant and dependents within the household. If Family income has changed, or if tax returns cannot be provided, annual income will be calculated by annualizing the prior six months of income from the Primary Applicant and dependents within the household.

You can obtain a copy of North Memorial Health's Financial Assistance Policy which describes NMH financial assistance programs, program eligibility, and covered services provided to eligible customers, by visiting the Financial Assistance Policy page of NMH's website at https://northmemorial.com/financial-assistance, or by calling (763) 581-0911, or (866) 494-2900.

Please use this table as a checklist when completing the enclosed application.	
Section 1 Applicant Information	☐ All boxes need to be filled in. ☐ If you were claimed as a dependent on someone else's tax return, the application is to be completed by that person.
Section 2 Dependent Inclusion	☐ Include all family members in the household for which you are financially responsible for. ☐ Dependents over the age of 18 will only be considered in the family size calculation if they are listed on the previous year's tax return. Any child over the age of 18 will need to apply separately.
Section 3 Proof of Liquid Asset Balance	☐ Please send us a complete statement for all assets itemized in Section 3. The statement(s) must include the statement date, account holders name, current asset value, and the financial institution name. A bank summary of your account is not acceptable.
Section 4 Proof of Insurance Coverage	☐ If anyone listed on the application is insured a copy of the front and back of the insurance card is needed for each insured individual on the financial assistance application. ☐ If anyone listed on the application is not insured a Medical Assistance and/or MinnesotaCare written determination, or documentation regarding exemption from the Affordable Care Act may be required, or an application for Medical Assistance or MinnesotaCare may be required.
Section 5,6,7,8 Proof of Income	☐ Provide the most recent year's federal tax return including Schedules C, E, & F, if applicable. Do not send W2's or state tax returns. For a copy of your Federal return, call 800-829-0922. ☐ Please provide most recent paycheck detail/stub for Primary Applicant and all Family Members in the household. ☐ If the Primary Applicant and Family Members have no income a shelter statement must be completed. ☐ If you collect Social Security, pension, annuities, or unemployment please list that information (Section 7) and send proof of gross income. Bank statements showing net deposits are not acceptable as proof of income.
APPLICATION	☐ The information on the application must match the supporting documentation exactly. ☐ Please send clear photocopies of all required documentation. Do not send originals, since they will not be returned. ☐ Application must be completed fully, signed, and dated by the Primary Applicant.

If you are unsure about what documentation to include with your application, or if you need any other assistance, please contact the appropriate phone number below:

North Memorial Health/Maple Grove Hospital
(763) 581-0911 or (866) 494-2900

North Memorial Transportation
(763) 581-9930 or (800) 535-6720

NORTH MEMORIAL HEALTH

MAPLE GROVE HOSPITAL

Guarantor / Account #:

Financial Assistance Application

Please indicate the entity for which you have balances and are applying financial assistance for:

☐ North Memorial Health Hospital/Clinic ☐ Maple Grove Hospital ☐ Medical Transportation
☐ North Memorial Outpatient Pharmacy ☐ Reference Lab

1. PRIMARY APPLICANT: (If applying for a minor child, enter **YOUR** name here, and list the child in Section 2 below)
All boxes must be filled in and match supporting documentation exactly.

First Name	M.I.	Last Name	Date of Birth	Sex ☐M ☐F	Marital Status
Address		City		State	Zip Code
Social Security Number		Home Phone		Other Phone	

2. FAMILY MEMBER(S) LIVING IN YOUR HOUSEHOLD FOR WHICH YOU ARE FINANCIALLY RESPONSIBLE FOR:

NAME (First, M.I., Last)	Date of Birth	Relationship to You

3. PLEASE COMPLETE THE FOLLOWING LIST OF ASSETS YOU HAVE FOR THE PRIMARY APPLICANT AND ALL FAMILY MEMBERS LISTED IN SECTION 2 WITHIN THE HOUSEHOLD AND PROVIDE SUPPORTING DOCUMENTATION.

****REQUIRED ASSET VERIFICATION DOCUMENTS **:** YOU MUST PROVIDE YOUR MOST RECENT STATEMENT(S) VERIFYING THE BALANCE/VALUE OF EACH ASSET LISTED BELOW. EACH STATEMENT MUST CLEARLY IDENTIFY THE ACCOUNT HOLDER OF THE ASSET, DATE, AND INSTITUTIONAL NAME.

Asset Type	Statement Date	Name on Account	Asset Value	Financial Institution
Checking and Savings Accounts				
Stocks/Bonds/Certificate of Deposit/Money Market Accounts/Mutual Funds/IRA				
Health Retirement/Health Savings Account				

☐ **I (We) do not have any of the assets listed, including checking and savings accounts.**

4. HEALTH INSURANCE INFORMATION: Please answer the following questions for yourself, as the primary applicant, and family members listed in Section 2. Attach a copy of each person's insurance card, if applicable.

****REQUIRED HEALTH INSURANCE DOCUMENTATION**:** If anyone listed on this application does not have medical coverage (Medical Assistance, MinnesotaCare, Medicare, or Other), please provide written explanation in Section 9 as to why insurance was not obtained. A current & valid determination letter from Medical Assistance/MinnesotaCare for that person, or documentation regarding exemption from the Affordable Care Act Regulations may be required	
Please send a copy of the front and back of the insurance card listing each person that is covered by that insurance.	
Do you have Medicare? ☐ No ☐ Part A ☐ Part B	Does your spouse have Medicare? ☐ No ☐ Part A ☐ Part B
Does anyone have Medical Assistance or MinnesotaCare? ☐ No ☐ Yes	IF Yes, who has Medical Assistance or MinnesotaCare?
Does anyone have additional health insurance? ☐ No ☐ Yes	IF YES, what is the name and phone # of the insurance and who is covered?

5. EMPLOYMENT VERIFICATION: Please complete and provide your most recent paycheck detail/stub for the Primary Applicant and all Family Members listed in Section 2 who are employed within the household.

a. Employed Worker's Name	b. Employer/Business Name	c. Hourly wage/ Annual Salary	d. Hours worked per week	d. Tips
PRIMARY APPLICANT				

6. INCOME VERIFICATION: Please attach copies of the IRS 1040, or 1040A tax return(s) including schedules C, E & F from the most recent tax filing year for the Primary Applicant and all Family Members within the household. If a tax return is not available, you must complete Section 7.

☐ **I (We) do not file a tax return. Please provide 6 months' paycheck detail/stub for primary applicant and employed family members.**

7. If a current tax return for all family members listed in Section 2 within the household cannot be provided, or your Family Income has changed, since the recent year tax filing, please provide the following Family Income for the Primary Applicant and all Family Members listed in Section 2 in the household:

SOURCEs OF INCOME	AMOUNT - PAST SIX MONTHS	SOURCES OF INCOME	AMOUNT - PAST SIX MONTHS
Taxable Interest and Dividends		Rents/Royalties/Estates/Trusts	
Alimony/Child Support		Unemployment Compensation	
Self-employment income		Workers Compensation	
Social Security and Disability		Educational Assistance	
Pension and Retirement		Public Assistance	
Veterans Payments		Other financial assistance	

****REQUIRED VERIFICATION DOCUMENTS FOR OTHER SOURCES OF INCOME**:**

- **SOCIAL SECURITY, SSI, PENSION, UNEMPLOYMENT, and WORKER'S COMPENSATION**: Send your proof of benefits statement or award letter showing how much you receive each month. We require gross income amounts. A bank summary of net income is not acceptable.
- **ALL OTHER SOURCES OF INCOME:** Provide either (1) tax documents showing income received, or (2) some other form of "official" documentation verifying the income and source. A copy of your bank statement is not acceptable as proof of income.

8. **IF APPLICANT HAS NO INCOME REPORTED, A SHELTER STATEMENT OF SUPPORT MUST BE COMPLETED. PLEASE CALL OUR OFFICE TO OBTAIN A SHELTER STATEMENT, OR OBTAIN A COPY ON THE FINANCIAL ASSISTANCE POLICY PAGE OF OUR WEBSITE** https://northmemorial.com/financial-assistance.

9. If you have additional factors that you would like us to consider with your application, or you need additional space to provide information, please list the information below or use an addition piece of paper.

*******BEFORE RETURNING THIS APPLICATION, MAKE SURE YOU HAVE ATTACHED ALL REQUIRED DOCUMENTATION AS OUTLINED IN EACH SECTION*******	
I acknowledge that the information of this application is true and correct to the best of my knowledge. I understand that misrepresentation of the information on this application could result in denial of your financial assistance application request.	
DATE:	**PRIMARY APPLICANT'S SIGNATURE:** **X**

Please allow 30 days for processing. Incomplete applications cannot be processed. You will receive notification by mail of our decision.

Completed applications including all required information and documentation should be submitted for financial assistance eligibility determination to:

- Mail: North Memorial Hospital – Financial Assistance, 3300 Oakdale Avenue North, Robbinsdale, MN 55422
- Email: FAA@NorthMemorial.com
- Delivered in person at the following locations:
  - NMH Admitting Departments
  - North Memorial Health Business Office, 3500 France Avenue North, Suite 106, Robbinsdale, MN 55422
  - North Memorial Health Transportation, 4501 68th Avenue North, Brooklyn Center, MN 55429

***Family Income:** Family Income is determined starting with the Census Bureau definition, which uses the following income when computing federal poverty guidelines: Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, disability benefits, pension or retirement income, interest, dividends, rents, royalties, and estates and trusts, educational assistance, alimony, child support, financial assistance from outside the household, and other miscellaneous sources;

1. Noncash benefits (such as food stamps and housing subsidies) do not count;
2. Determined on a before-tax basis;
3. Excludes capital gains or losses; and
4. If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

****Federal Poverty Guidelines (FPG):** The FPG establishes the levels of annual income for poverty as determined by the United States Department of Health and Human Services and are updated annually in the Federal Register.