NORTH
MEMORIAL HEALTH

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 hospitals, emergency transportation, and 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. ☐ Dependents over the age of eighteen 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 eighteen 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 holder's 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 not insured the following items may be required: A Medical Assistance and/or MinnesotaCare written determination, documentation regarding exemption from the Affordable Care Act, or an application for Medical Assistance or MinnesotaCare may be required. Applicants are expected to seek reasonable efforts to obtain medical insurance coverage prior to charity being considered.
Section 5,6,7,8 Proof of Income	☐ Provide the most recent year's Federal tax return including Schedules 1, C, E, & F, if applicable. **Do not send W2's or state tax returns**. ☐ If you did not file a federal tax return, copies of the past 6 months of paystubs are required. ☐ 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 current income, a No Income Attestation must be completed. ☐ If you collect Social Security, pension, annuities, or unemployment please list that information (Section 7) and send proof of these incomes. Bank statements showing net deposits are not acceptable. ☐ Ensure all attestations are marked as applicable
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.

NORTH MEMORIAL HEALTH

Guarantor / Account #(s):

Financial Assistance Application

Please select the entities where you have an outstanding balance and for which you are seeking financial assistance

☐ North Memorial Health Hospital/Clinic ☐ Maple Grove Hospital ☐ Medical Transportation
☐ North Memorial Outpatient Pharmacy ☐ North Memorial Health Hospice & Home Health

1. PRIMARY APPLICANT: Please complete your personal information below. If applying for a minor child, enter **YOUR** name here, and list the child in Section 2 below.

Full Name		Date of Birth	Primary Phone	
Address	City		State	Zip Code
Marital Status: (Check One) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Spouse/Partners Name		Date of Birth	

2. FAMILY MEMBER(S): Please list all dependents claimed on your federal taxes.

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

3. ASSET VERIFICATION: Please complete the following list of assets you have for the primary applicant and all family members listed in Section 2. Please provide supporting documentation for any assets listed.

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 following: Account holder, statement date, institutional name, and account number. Please do not redact any information and include all pages of the statement(s). Missing pages, missing identifiers, or redacted information will result in a re-request for information.

Asset Type *(Examples)*	Statement Date	Name on Account	Account Balance	Financial Institution
-Checking Accounts -Savings Accounts -Money Market Accounts				
-Stocks/Bonds -Certificate of Deposit -Mutual Funds -IRA				
-Health Retirement -Health Savings Account				

☐ **I attest that I and all other household members do not have any of the assets listed above, including checking and savings accounts.**

4. HEALTH INSURANCE INFORMATION: Please answer the following questions for yourself, as the primary applicant, and all family members listed in Section 2.

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 determination letter from Medical Assistance/MinnesotaCare for that person, or documentation regarding exemption from the Affordable Care Act Regulations may be required.			
Do you have Medicare? (check all that apply)	☐ No	☐ Yes- Part A	☐ Yes- Part B
Does your spouse have Medicare? (check all that apply)	☐ No	☐ Yes- Part A	☐ Yes- Part B
Does anyone have Medical Assistance or MinnesotaCare?	☐ No	☐ Yes	
If YES, who in the household has Medical Assistance or MinnesotaCare?			
Does anyone have additional health insurance?	☐ No	☐ Yes	
If YES, what is the name of the insurance, member ID # and who in the household 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.

Employed Worker's Name	Employer/Business Name	Hourly wage/ Annual Salary	Hours worked per week	Tips

6. INCOME VERIFICATION: Please attach copies of the IRS 1040, or 1040A tax return(s) including schedules 1, 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 cannot be provided or the family income has changed since the recent year tax filing, please provide 6 months' paycheck detail/stub for the primary applicant and employed family members and mark the attestation below.

☐ **I attest that I and all other household members do not file a tax return.**

7. **OTHER INCOME VERIFICATION:** Please complete the section below with any additional sources of income the primary applicant or household family members receive**.**

REQUIRED SOURCES OF INCOME DOCUMENTATION

SOCIAL SECURITY, SSI, PENSION, UNEMPLOYMENT, and WORKER'S COMPENSATION: Please include 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: Please provide one of the following: tax documents showing income received, or some form of official documentation verifying the income and source. A copy of your bank statement is not acceptable as proof of income.

Sources of Income	Amount- Past 6 Months	Sources of Income	Amount- Past 6 Months
Alimony		Rents/Royalties/Estates/Trusts	
Child Support		Unemployment Compensation	
Self-employment income		Workers Compensation	
Social Security and Disability		Educational Assistance	
Pension and Retirement		Public Assistance	
Veterans Payments		Other	

8. **APPLICANT HAS NO INCOME REPORTED:** If it has been reported above that primary applicant and household family members have no employment or other income in the last 6 months, please complete the attestation below and include an explanation on how living expenses are paid for such as food and shelter.

☐ **I attest that I and all other household members have no income including employment or other income.**

9. **ADDITIONAL INFORMATION: (Optional)** If there are any additional circumstances you would like us to consider as part of your application review, or if you require additional space to provide information, please include those details below or attach a separate sheet.

BEFORE RETURNING THIS APPLICATION, MAKE SURE YOU HAVE ATTACHED ALL REQUIRED DOCUMENTATION AS OUTLINED IN EACH SECTION

I acknowledge that the information on 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.

Primary Applicant's Signature:	**Date:**

Please allow 30 days for processing. Incomplete applications will not be processed. You will be notified of our decision by mail.

Completed applications, including all required documentation, can be submitted via the following methods:

- MyChart: Application can be completed through your MyChart account. Once logged into MyChart, select Financial Assistance in the menu
- Mail: North Memorial Business Office – 3500 France Avenue North, Suite 106, Robbinsdale, MN 55422
- Email: FAA@NorthMemorial.com
- Fax: (763) 581-4491
- Delivered in person at the following locations:
    - North Memorial Health – Robbinsdale Hospital Registration Department
    - North Memorial Health – Maple Grove Hospital Registration Department
    - North Memorial Health Business Office - 3500 France Avenue North, Suite 106, Robbinsdale, MN 55422
    - North Memorial Health Ambulance Services, 4501 68th Avenue North, Brooklyn Center, MN 55429

If you have questions about what documentation to include with your application, or if you need any other assistance, please contact the appropriate department below:

- **North Memorial Health Hospitals and Clinics**
    - (763) 581-0911 or (866) 494-2900
    - FAA@NorthMemorial.com
- **North Memorial Health Ambulance Services**
    - (763) 581-9930 or (800) 535-6720

***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;

- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, it 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.