



If you are interested in applying for financial assistance, please complete this application. Contact Patient Accounting at 651-265-1999 (or toll-free at 1-877-655-2669) with questions.

Medical Group & Clinics			<i>HealthPartners Account #</i>		
Financial Assistance Program Application					
Name		Date of Birth	Home Phone		
Address		City	State	Zip	
Marital Status		Spouse's name			
Applicant		Spouse			
Employer		Employer			
Employment (FT / PT, Salaried /Hourly) # of hrs/wk?		Employment (FT / PT), Salaried /Hourly) # of hrs/wk?			
Position		Position			
Employer's address		Employer's address			
City / State / Zip		City / State / Zip			
Social Security #		Social Security #			
Dependents (How many claimed on taxes?)	Name(s)		Date of Birth		
A copy of your most recent income tax return (with attachments) must be returned with this statement					
Income (list all family income)		Total for the last three months		Total for the last 12 months	
Wages and tips					
Farm and self employment					
Public assistance					
Social security and disability					
Unemployment					
Worker's compensation					
Strike benefits					
Alimony					
Child support					
Military family allotments					
Pensions or tax deferred annuities					
Income from annuities, investments, dividends					
Stocks, mutual funds					
Rent					
Other					
Total					
Value of personal property		Real estate value: Home		Real estate value: Other	
Value of automobile #1		Make		Model and Year	
Value of automobile #2		Make		Model and Year	
Checking acct. balance		Bank			
Savings acct. balance		Bank		Investment account balance CD, stocks, bonds	

Read and Sign

I will notify Health Partners of any material changes in the statements provided on this form. I understand that this financial statement is to retain financial assistance and a credit bureau check will be obtained to verify eligibility. It will be treated as confidential information.

Signature	Date
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Debt – list all outstanding debt and monthly payments

Type	Monthly payments	Remaining balance	Date loan will be paid
Mortgage, taxes and insurance			
Rent			
Automobile payments and insurance			
Utilities(telephone, gas, water, sewer, electric)			
Life insurance			
Groceries			
Dependent care/child support			
Medications & medical supplies			
Education/Student loans/Tuition and books			
Credit cards			
Transportation(other than auto)			
Other loans			
Other liabilities			
Total	\$	\$	

Insurance information

Do you have insurance to cover medical expenses? <input type="checkbox"/> yes <input type="checkbox"/> no	Notify our office of any insurance changes.
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Primary

Name of insurance company	Effective date
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Address

Contact person	Policy number	Group number
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Secondary

Name of insurance company	Effective date
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Address

Contact person	Policy number	Group number
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Authorization and Assignment of Basic and Major Medical Insurance Benefits

I hereby authorize HealthPartners Medical Group and Clinics and any health care provider of HealthPartners Medical Group and Clinics to release any medical information to my insurance company.

Signature	Date
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I hereby authorize and request my insurance carrier to make payments directly to HealthPartners Medical Group and Clinics. ANY BASIC AND/OR MAJOR MEDICAL BENEFITS DUE UNDER THE TERMS OF THIS POLICY FOR SERVICES RENDERED BY HEALTHPARTNERS MEDICAL GROUP & CLINICS.

Signature	Date
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Return completed application and information to:

HealthPartners Medical Group & Clinics
Patient Accounting
Mail Stop: 25508B
P.O. Box 244
Minneapolis, MN 55440-1309

