Allina Health
Partners Care 10209
PO Box 43
Minneapolis MN 55440-0043

Allina Health
Hours: Monday - Thursday 8:00am - 4:30pm
Friday 9:00am - 4:30pm
(612) 262-9000 or (800) 859-5077
Email address: AllinaPartnersCare@allina.com

ALN-645

Thank you for your interest in Allina Partners Care (APC). APC is a financial assistance program through Allina Health that can assist with your Allina Health medical bills. Enclosed, you will find the APC application. Please keep the following in mind while completing the application:

- APC is not health insurance, and is financial assistance for your Allina Health bills only. Because it is not a health insurance plan, APC can only cover services that are billed directly through Allina Health. This means that it can only assist with charges for Allina Health facilities, and charges incurred with doctors employed by Allina Health.
- APC assists with your bills for medically necessary services, and does not assist with bills for prescription medications, retail services, or some elective services.
- When filling out the application, it is important that you provide us with current insurance, income, and asset information, even if your situation has changed since you incurred your bills with Allina Health. APC eligibility is based on your current house hold income and assets.

Please use this table as a checklist when completing the enclosed application.	
Section 1 Applicant Information	❑ Application must be fully completed - **All boxes need to be filled in.** ❑ The information on the application has to match the supporting documentation **EXACTLY!** ❑ Application must be signed and dated by applicant and spouse/significant other (see section 2).
Section 2 Dependent Inclusion	❑ 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. *Please also list them on application as a dependent.* Any child over the age of 18 will need to apply for Allina Partners Care separately. ❑ If you are living with a significant other and you share a minor child together, we will consider your income as a family income. Please list the significant other and the child on the application, and provide all supporting financial documentation.
Section 3 Proof of Insurance Coverage	❑ If anyone listed on the application has current healthcare coverage, please indicate this and send a copy of the front and back of the health insurance card. ❑ If anyone listed on the application is uninsured, we will need a written determination from Medical Assistance and/or MN Care.
Section 4 Proof of Liquid Asset Balance	We need clear photocopies (**do not send originals, they will not be returned**) of the following: ❑ Bank statements, stocks/bonds, CD's, money market accounts. ❑ Please send us a complete monthly statement. It must include your name, institution name, all transactions, a current balance and a date. A bank summary of your account is not acceptable. The information in Section 4 must match exactly what your supporting documentation shows.
Section 5, 6, 7, 8 Proof of Income *** Send copies of all that apply**	❑ Copies of the 2 most recent pay stubs or employer statement listing 2 months of pay (if employed). ❑ Previous year's federal tax return. ❑ If applicants have no income at all, a statement of support must be completed - Call our office to obtain a copy if needed. ❑ We need to have supporting documentation for any income listed in these sections. ❑ If retired and collect social security, pension or annuities please list that information in Section 7 and send proof of the gross income. Bank statements showing net deposits are not accepted as proof of income.

If you are unsure about what documentation to include with your application, or if you need any other assistance with this application, please contact us at the phone numbers above. You can download a copy of this application in English, Spanish or Somali at www.allinahealth.org/financialassistance.

LD

Sincerely,
Your Allina Partners Care Specialists

Allina Health
Partners Care 10209
PO Box 43
Minneapolis. MN 55440-0043

Allina Partners Care

Financial Assistance Application

IMPORTANT: IF THIS APPLICATION IS NOT COMPLETELY FILLED OUT, YOU WILL BE ASKED TO COMPLETE A NEW ONE.

1. PRIMARY APPLICANT (If applying for a minor child, enter **YOUR** name here, and list the child as a dependent in Section 2 below)

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	SEX ❑ M ❑ F	MARITAL STATUS

STREET ADDRESS	CITY	STATE	ZIP CODE

Are you a U.S. Citizen? ❑ Yes ❑ No	IF YES, SOCIAL SECURITY NUMBER	HOME PHONE	OTHER PHONE

2. OTHERS LIVING WITH YOU? Do you have a Spouse and/or any dependents living in your home? ❑ No ❑ Yes - Fill in below

** We need to consider your entire household when reviewing for Allina Partners Care. If you are living with a significant other and share a child together, you should list them below and include all of their financial information.*

NAME (First, M.I. Last)	Date of Birth	Relationship to You	Us Citizen or US National? (Only fill in 2b if ✓ NO)	**2b** Immigration Status?	**2b** Sponsor Name
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		

**** REQUIRED HEALTH INSURANCE DOCUMENTATION**:**

• IF ANYONE LISTED ON THIS APPLICATION DOES NOT HAVE MEDICAL COVERAGE (MEDICAL ASSISTANCE, MN CARE, MEDICARE, OR OTHER): Please provide: written explanation regarding why insurance was not obtained and a current and valid determination letter from MN care for that person, or documentation regarding exemption from the affordable care act regulations. ****A COPY OF HEALTHCARE CARD NEEDS TO BE INCLUDED.**

3. HEALTH INSURANCE INFORMATION Please answer the following questions for yourself, as well as everyone you listed above in section 2. Please provide: a written explanation regarding why insurance was not obtained; a current and valid determination letter from MNcare for that person; or documentation regarding exemption from the affordable care act regulations.

a. Do you have Medicare? ❑ No ❑ Part A ❑ Part B	Does your Spouse/Significant Other have Medicare? ❑ No ❑ Part A ❑ Part B
b. List current health insurance for each of the family members listed above: (Example: Jane Doe has Blue Cross Blue Shield)	(List Insurance Information Here)
c. If any family members listed above do not have health insurance, please briefly explain why.	(Explanation)
Please send a copy of the front & back of the insurance card listing each person that is covered by that insurance.	

****REQUIRED ASSET VERIFICATION DOCUMENTS**:**

• YOU MUST PROVIDE YOUR MOST RECENT STATEMENT(S) VERIFYING THE BALANCE/VALUE OF EACH ASSET LISTED BELOW. EACH STATEMENT SHOULD CLEARLY IDENTIFY YOU AS THE OWNER OF THE ASSET. *"EACH COLUMN NEEDS TO BE FILLED IN FOR EVERY ASSET – PLEASE SEE EXAMPLE LINE BELOW."*

4. DO YOU (OR YOUR SPOUSE/SIGNIFICANT OTHER, IF APPLICABLE) HAVE ANY OF THE FOLLOWING ACCOUNT TYPES OR ASSETS?

❑ Checking acct. ❑ Savings acct. ❑ Pre-PayDebit Card ❑ Stocks/bonds ❑ Certificate of Deposit ❑ Money Market accts. ❑ No Assets

(Fill in below – If more lines are needed, use a separate sheet).

a. Statement date from attached verification documents (MM/YY)	b. Asset Owner's Name	c. Type of Asset	d. Name of Financial Institution
Example: 01/2016 (January 2016)	*Jane Doe*	*Checking Account*	*Bank of Allina*

APPLICATION CONTINUED ON REVERSE SIDE

****REQUIRED EMPLOYMENT INCOME VERIFICATION DOCUMENTS**:**
• PROVIDE **(1)** A COPY OF YOUR 2 MOST RECENT PAYCHECK STUBS FROM EACH EMPLOYER AND **(2)** A COPY OF YOUR PREVIOUS YEAR'S FEDERAL INCOME TAX FORM 1040

5a. ARE YOU EMPLOYED? ❑ No ❑ Yes - Fill in Below
5b. IS YOUR SPOUSE/SIGNIFICANT OTHER EMPLOYED? ❑ No ❑ Yes - Fill in Below

a. Employed worker's name	b. Employer's Name	c. Hourly wage/salary	d. Hours worked per week	e. Tips
		$		$
		$		$
		$		$

****REQUIRED SELF-EMPLOYED INCOME VERIFICATION DOCUMENTS**:**
• PROVIDE A COPY OF YOUR PREVIOUS YEAR'S FEDERAL INCOME TAX FORM 1040 INCLUDING ALL SCHEDULES

6a. ARE YOU SELF-EMPLOYED? ❑ No ❑ Yes - Fill in Below
6b. IS YOUR SPOUSE/SIGNIFICANT OTHER SELF-EMPLOYED? ❑ No ❑ Yes - Fill in Below

a. Self-employed worker's name	b. Business Name	c. Start Date	d. Yearly Income (Line 12 from your 1040 form)
			$
			$

****REQUIRED VERIFICATION DOCUMENTS FOR THESE SOURCES OF INCOME**:**
• **SOCIAL SECURITY, SSI, PENSION, UNEMPLOYMENT, WORKER'S COMPENSATION, PUBLIC ASSISTANCE:** Send your proof of benefits statement or award letter showing how much you receive each month
• **A COPY OF YOUR BANK STATEMENT IS NOT ACCEPTABLE AS PROOF OF INCOME.**
• **ALL OTHER SOURCES OF INCOME:** Provide either (1) tax documents showing the income received, or (2) some other form of official documentation verifying the income and source.
• **PROVIDE A COPY OF YOUR PREVIOUS YEAR'S FEDERAL TAX INCOME FORM 1040 INCLUDING ALL SCHEDULES**

7. DO YOU (OR YOUR SPOUSE/SIGNIFICANT OTHER, IF APPLICABLE) RECEIVE INCOME FROM A SOURCE OTHER THAN WORK?
INCLUDE:

- Social Security
- Supplemental Security Income (SSI)
- Minor Child SSI
- Spousal Support
- Worker's compensation
- Trusts
- Unemployment
- Rental Income
- VA Benefit
- Interest
- Dividends
- Public Assistance
- Child Support
- Retirement/Pension
- Any other income

❑ No ❑ Yes - Fill in Below

***** AMOUNTS LISTED IN COLUMN c. BELOW MUST MATCH SUPPORTING DOCUMENTATION *EXACTLY* *****

a. Income recipient's name	b. Type of income	c. Amount	d. How often received
		$	
		$	
		$	

8. IF APPLICANT HAS NO INCOME REPORTED, A STATEMENT OF SUPPORT MUST BE COMPLETED. PLEASE CALL OUR OFFICE TO OBTAIN A COPY. IF YOU HAVE ADDITIONAL FACTORS THAT YOU WOULD LIKE US TO CONSIDER WITH YOUR APPLICATION, PLEASE LIST THEM HERE. USE AN ADDITIONAL PIECE OF PAPER IF NECESSARY.

9. ** BEFORE RETURNING THIS APPLICATION, MAKE SURE YOU HAVE ATTACHED ALL REQUIRED DOCUMENTATION AS OUTLINED ABOVE******

I acknowledge that the information on this application is true and correct to the best of my knowledge, and I hereby authorize Allina Health to release this information to any physician, clinic, affiliate, and/or other area hospital or clinic to which I am referred. I also acknowledge that I must enroll in and fully utilize and comply with (1) any Minnesota Health Care programs that I may qualify for, or (2) any medical insurance that may be available to me through an employer, a health exchange (ex: MNsure), and that failure to do so could result in removal from the Allina Partners Care Program.

DATE	PRIMARY APPLICANT'S SIGNATURE
DATE	SPOUSE'S/SIGNIFICANT OTHER'S SIGNATURE

PLEASE ALLOW 30 DAYS FOR PROCESSING YOU WILL RECEIVE NOTIFICATION OF OUR DECISION BY MAIL