Children's Financial Assistance Application

Check all that apply:

☐ Minneapolis ☐ St. Paul ☐ Minnetonka ☐ HTC ☐ Homecare ☐ Children's Hugo ☐ Metro Peds ☐ Partners in Pediatrics ☐ Children's West St. Paul

A copy of your most recent federal income tax return (with schedules) must be returned with this application.			
Your Name		DOB	Phone
Street Address		City	State	Zip Code
Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Legally Separated	Spouse's Name	Date of Birth	# of Dependents, including yourself
Do the Children's patients you are applying for have insurance? ☐ Yes ☐ No			
Household Members (Please include the patient(s) you are applying for, everyone listed on your taxes, and every family member that resides with you.)			
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Name		DOB	Relationship
Employment Information			
Applicant: ☐ Employed ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled ☐ Other:			
Spouse: ☐ Employed ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled ☐ Other:			
☐ Check this box if you choose to apply for Medical Assistance and would like a call from a Financial Counselor to assist you. ☐ Check this box if you choose to apply for Medical Assistance through MNsure.org and have included proof of your application. ☐ Check this box if you choose NOT to apply for Medical Assistance and would like the uninsured discount (based on policy guidelines).			
Read and Sign			
• I/We declare that the information released in this financial statement is accurate and complete to the best of my/our knowledge. I/we understand that this information is strictly confidential and will not be released to other parties not associated with Children's Hospitals and Clinics of Minnesota without my/our specific written authorization. • I/we authorize Children's Hospitals and Clinics of Minnesota to receive federal and state records of employment and income history, including state employment security agency records, to be used for consideration in the application of Children's Hospitals and Clinics uncompensated care/reduced payment policy process. • I will notify Children's of any material changes in the statements provided on this form.			
Applicant Signature:			Date:
Co-Applicant Signature:			Date:

For Financial Counseling Use Only: Processed by/date_____ HH_____ GAI $_____

Date Received_____ Reviewed by/date_____ FPL_____ % Discount_____ %

☐ Non-covered service discount ☐ 30% Discount ☐ 44% Discount ☐ Exception only Data Entry: ☐Database ☐Cerner ☐Invision ☐Profit